**New Patient Registration Form** Please complete all pages in full using block capitals

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| **1. Background Details** | | | | | | | |
| **Contact Details** | | | | | | | |
| NHS Number |  | | | *If you have had a previous GP then you will find this on letters/prescriptions or at* [*www.nhs.uk/find-nhs-number*](https://eur01.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.nhs.uk%2Ffind-nhs-number&data=04%7C01%7Csupport%40ardens.org.uk%7Cffabf11787fb41dc43be08d99fa70d67%7C2574bae132844b5a8833850acab88d43%7C1%7C0%7C637716362095841893%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=MF3g4y6zrx4E0Qifat%2FgKNmjXrzmgNeU5ebPuaEcNAo%3D&reserved=0) | | | |
|  | I do not know my NHS number | | | | | | |
| First Name |  | | | Surname | |  | |
| Previous Surname  (if applicable) |  | | | | | | |
| Gender | Non-binary  Female  Male  Prefer not to say  Unable to answer | | | | | | |
| Address  (including post code) |  | | | Date of Birth | |  | |
| Home Telephone | |  | |
| Work Telephone | |  | |
| Previous Address |  | | | | | | |
| Mobile Telephone | I consent to be contacted by SMS on this number: | | | | | | |
| Email | I consent to be contacted by email at this address: | | | | | | |
| Next of Kin | Name: | | Tel: |  | | Relationship: |  |
| Family Registered With Us | |  | | | | | |
| Has the patient been registered in the NHS before?  Yes  No  If no please state date entered UK: | | | | | | | |
| Previous GP | Name: | | Address: | |  | | |

*\* It is your responsibility to keep us updated with any changes to your telephone number, email & postal address.*

*We may contact you with appointment details, test results, health campaigns or Patient Participation Group details*

*If you do not consent to being contacted by SMS or Email, please tick here:  SMS  Email*

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| **Other Details** | | | | |
| Country of Birth |  | | | |
| Ethnicity | White (UK)  White (Irish)  White (Other) | Black Caribbean  Black African  Black Other | Bangladeshi  Indian  Pakistani | Chinese  Other |
| Housing | Own House  Rented House  Shared House | Nursing Home  Residential Home  Sheltered Home | Homeless  Housebound | Asylum Seeker  Refugee |
| Overseas Visitor | Yes | European Health Insurance Card Held (please bring details with you) | | |
| Armed Forces | Military Veteran | Family member |  |  |
| **Communication Needs** | | | | |
| Language | What is your main spoken language?  Do you need an interpreter?  Yes  No | | | |
| Communication | Do you have any communication needs?  Yes  No (If **Yes** please specify below) | | | |
| Hearing aid  Lip reading | Large print  Braille | British Sign Language  Makaton Sign Language  Guide dog | |
| Learning disability | Do you have a Learning Disability?  Yes  No  (If **Yes** please request a Learning Disability Screening Tool form) | | | |

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| **Carer Details** | | | | | |
| **Are you** a carer? | Yes – Informal / Unpaid Carer | | Yes – Occupational / Paid Carer | | No |
| Do you **have** a carer? | Yes | Name: | Tel: | Relationship: | |

*\* Only add carer’s details if they give their consent to have these details stored on your medical record*

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| **Emergency Contact or Next of Kin** | | | |
| First Name |  | Surname |  |
| Relationship to you |  | | |
| Address  (including post code) |  | Mobile Telephone |  |
| Home Telephone |  |

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| **2. Medical History** | | | |
| **Medical History** | | | |
| Have you suffered from any of the following conditions? | | | |
| Asthma  COPD  Epilepsy | Heart Disease  Heart Failure  High Blood Pressure | Diabetes  Kidney Disease  Stroke | Depression  Underactive Thyroid  Cancer- Type: |
| Any other conditions, operations or hospital admission details:  If you are currently under the care of a Hospital or Consultant outside our area, please tell us here: | | | |

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| **Family History** | | | |
| Please record any significant family history of close relatives with medical problems and confirm which relative e.g. mother, father, brother, sister, grandparent | | | |
| Asthma  COPD  Epilepsy | Heart Disease  Stroke  Blood Pressure | Diabetes  Kidney Disease  Liver Disease | Depression  Thyroid  Cancer |
| Other: | | | |

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| **Allergies** |
| Please record any allergies or sensitivities below |

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| **Vaccinations – NOTE\* SECTION FOR PATIENTS AGED 6 AND UNDER** |
| Please note that we require the vaccination history for all children aged 6 and under.  If you are completing this form on behalf of someone that is within this age group, please submit a copy of their vaccination records to the reception team. |
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| **Current Medication** |
| Please check and include as much information about your current medication below.    **Please note that we will need documentation for this such as a hospital letter or previous repeat medication list.** |

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| **Repeat Prescribing** | | |
| Most prescriptions are sent electronically to a pharmacy of the patient’s choice where they can collect their medication.  Please provide details of the pharmacy you would like to use: | | Pharmacy: |
| **Please note that we only requests prescription requests made online or via a pharmacy.** | | |
| Online | The most efficient way of ordering repeat prescriptions is by signing up to [Patient Access](https://www.patientaccess.com/)  or using [the NHS App](https://www.nhs.uk/using-the-nhs/nhs-services/the-nhs-app/) to request medications.  You can request to act as a **proxy** for children; relatives and dependants that you care for to use Patient Access or the NHS App on their behalf. This would enable you to access, manage parts of the patient’s GP online services account, and request for repeat prescriptions on their behalf. | |
| Pharmacy | We understand that some patients may find it difficult to order prescriptions online. If so, most pharmacies offer a repeat prescription request service. You can speak to your nominated pharmacy and set them up to order on your behalf. You can then submit your request to them via telephone or in person, and they will pass on your request to us.  Pharmacies can email repeat prescription requests to [prescriptions.grovesurgery@nhs.net](mailto:prescriptions.grovesurgery@nhs.net)  **Please note that we will only be accepting email requests from NHSmail addresses.** | |

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| **Reproductive Health – NOTE\* SECTION FOR PATIENTS AGED 16 AND OVER** | |
| Do you use any contraception? Do you have a coil or implant inserted:  Have you had a hysterectomy: | Yes  No If needed, please book appointment.  Yes  No Date inserted:  Yes  No Date: |
| Are you currently pregnant or think you may be? | Yes  No Expected due date: |

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| **3. Your Lifestyle – NOTE\* SECTION FOR PATIENTS AGED 16 AND OVER** | | | | | |
| **Alcohol** | | | | | |
| How often do you have a drink containing alcohol? | Never | Monthly or Less | 2-4 times per month | 2-3 times per week | 4+ times per week |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1-2 | 3-4 | 5-6 | 7-9 | 10+ |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |

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| **Smoking** | | | |
| Do you smoke? | Never smoked | Ex-smoker | Yes |
| Do you use an e-Cigarette? | No | Ex-User | Yes |
| How many cigarettes did/do you smoke a day? | Less than one | 1-9 10-19 | 20-39  40+ |
| Would you like help to quit smoking? | Yes | No |  |
|  | For further information, please see: [www.nhs.uk/smokefree](http://www.nhs.uk/smokefree) | | |

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| **Height & Weight** | | | |
| Height |  | Weight |  |
| Blood Pressure Reading | *For example, 120/80 mmHg* | Pulse Rate | *For example, 80* |

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| **4. Wider Determinants of Health Questions** | | | | |
| Do you have any problems with housing? | Yes | No |  |
| Do you have money problems that make it hard to meet your needs? | Yes | No |  |
| Do you feel lonely? | Yes | No |  |
| If you answered Yes to any of the questions, do you feel a referral for support would help? | Yes | No |  |

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| **5. Further Details** |

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| **Named Accountable GP** | |
| The GP who has overall responsibility for your care is? | Dr Moghul |

*You are however entitled to make an appointment to see any GP of your choice, subject to availability.*

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| **Signatures** | |
| Signature | I confirm that the information I have provided is true to the best of my knowledge.  Signed on behalf of patient |
| Name |  |
| Date |  |

**Checklist**

Please ensure the following are done and provided so that your registration can be completed successfully

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|  | Completed & Signed Above Form |
|  | Photo Proof of ID *e.g. Passport, Photo Driving License or Photo ID card* |
|  | Proof of Address  *e.g. Bank statement, Utility Bill or Council Tax from within the last 3 months* |

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| **6. Sharing Your Health Record** |
| **Your Health Record** |
| Do you consent to your GP Practice sharing your health record with other organisations who care for you?  Yes *(recommended option)*  No, never  Do you consent to your GP Practice viewing your health record from other organisations that care for you?  Yes *(recommended option)*  No |

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| **7. Online Access To Your Health Record** |
| **I wish to have online access to:** *Please tick all that apply* |
| Book appointments  Request medication |
| View my medical record (subject to policy)  View my Summary Care Record |
| Complete online questionnaires |

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| **I wish to access my medical record & understand & agree with each statement:** *Please tick all that apply* |
| I will be responsible for the security of the information that I see or download |
| If I choose to share my information with anyone else, this is at my own risk |
| I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement |
| If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible |

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| **Proxy Access** |
| If you are completing this registration form on the applicant’s behalf and require access to their online profile, please speak to the reception team to be set up. |

Please bring photographic proof of your identification in order for the sign-up process to be completed

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| **Signature** | |
| Signature |  |
| Name |  |
| Date |  |