

# New Patient Registration Form

## Instructions for completing this form

1. Complete a separate form for each family member to be registered
2. Complete in BLOCK CAPITALS and tick the boxes as appropriate

<b>1</b>	<b>Full Name:</b>				<b>Date of Birth:</b>	
	<b>Title :</b> <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms				<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other. <i>Please state :</i>	
	<b>Other. <i>Please state :</i></b>				<b>Marital Status:</b>	
	<b>Mobile tel. number:</b>				<b>Maiden name / Mothers name if different:</b>	
	Text messaging service enables your GP Practice to get in touch with you by sending text messages to your mobile phone (e.g. text appointment reminders). You are able to text back to cancel or rebook your appointments and send responses to questions.  <b>IF YOU CHANGE YOUR MOBILE NUMBER, PLEASE LET YOUR GP KNOW AS SOON AS POSSIBLE.</b>  If you don't want to receive text messages from your practice tick here: <input type="checkbox"/>				<b>Current Address:</b>	
	<b>Work tel. number:</b>				<b>E-mail address:</b>	
					<b>If you consent to us sending you emails to this address please tick here:</b> <input type="checkbox"/>	
	<b>Next of Kin:</b>				<b>Next of Kin contact tel. number:</b>	
	<b>Relationship to Patient:</b>					
	<b>Please indicate your first choice of contact method:</b>					
<input type="checkbox"/> Letter <input type="checkbox"/> Email <input type="checkbox"/> SMS (text) <input type="checkbox"/> Phone						
<b>Town* and Country of birth</b>		<b>Country:</b>		<b>Borough (*If born in London):</b>		
(*If town is London please state which Borough) <b>Town:</b>						
<b>Please list other relatives of your home who are registered with us:</b>						
<b>Relationship:</b>		<b>Name:</b>		<b>Date of Birth:</b>		

<b>2</b>	<b>Looking After Someone</b>	
	<b>Are you looking after someone?</b> Let us know if you are looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems.	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<b>Is someone looking after you?</b> Let us know if a family member, friend or neighbour looks after you. If yes, they are your carer. You are welcome to invite your carer to accompany you to visits at the practice.	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<b>Carer's name :</b>	<b>Relationship to you:</b>
<b>Address of carer :</b>		
<b>Telephone number of carer :</b>		

<b>3</b>	<b>Are You Currently Employed?</b>			
	<b>If so please specify whether :</b>	<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Self-employed
	<b>If you are not employed, please indicate which best describes you:</b>			
	<input type="checkbox"/> Retired	<input type="checkbox"/> Student	<input type="checkbox"/> Housewife/ Homemaker/House husband	<input type="checkbox"/> Unemployed
	<input type="checkbox"/> Other <i>Please state:</i>			
	<b>If returning from the Armed Forces please state which below: Comments:</b>			
<input type="checkbox"/> Army	<input type="checkbox"/> Royal Navy	<input type="checkbox"/> Royal Air force		

<b>4</b>	<b>Your Religion</b> (Please tick) (*PS=please state)		<input type="checkbox"/> C of E	<input type="checkbox"/> Catholic	<input type="checkbox"/> Other Christian *PS _____	<input type="checkbox"/> Bhuddist	<input type="checkbox"/> Hindu	<input type="checkbox"/> Muslim	
			<input type="checkbox"/> Sikh	<input type="checkbox"/> Jewish	<input type="checkbox"/> Jehovah's Witness	<input type="checkbox"/> No religion	<input type="checkbox"/> Other religion *PS _____		
	<b>Your Ethnic Origin</b> (Please tick one)		<input type="checkbox"/> White (UK)		<input type="checkbox"/> White (Irish)	<input type="checkbox"/> White (Other)			
	<input type="checkbox"/> Black Caribbean/British		<input type="checkbox"/> Indian/British Indian		<input type="checkbox"/> Arabic	<input type="checkbox"/> Other Mixed Background			
	<input type="checkbox"/> Black African / British		<input type="checkbox"/> Pakistani <input type="checkbox"/> British Pakistani		<input type="checkbox"/> Chinese	<input type="checkbox"/> Other Asian Background			
<input type="checkbox"/> Other Black Background		<input type="checkbox"/> Bangladeshi / British Bangladeshi		<input type="checkbox"/> Other	<input type="checkbox"/> Ethnic Category Refused				
<b>What is your main spoken language?</b>					<b>Do you need an Interpreter?</b>				
Do you speak English? Yes <input type="checkbox"/> No <input type="checkbox"/>					Yes <input type="checkbox"/> No <input type="checkbox"/>				
<b>Do you need help with mobility/hearing/speaking?</b> (tick all that apply)									
<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Walking aid	<input type="checkbox"/> Hearing aid	<input type="checkbox"/> British sign language (BSL)		<input type="checkbox"/> Makaton sign language				
<input type="checkbox"/> Lip reading	<input type="checkbox"/> Large print	<input type="checkbox"/> Braille	<input type="checkbox"/> Other *PS _____						
<b>Are you currently?</b>		Homeless <input type="checkbox"/>	A Refugee <input type="checkbox"/>	An Asylum Seeker <input type="checkbox"/>					
<b>Are you housebound?</b>		Yes <input type="checkbox"/> No <input type="checkbox"/>		Comments:					

Please state any country (outside UK) that you have visited/lived in for more than 6 months during the past 5 years	
<b>Country:</b>	<b>Dates/Year (If known):</b>

<b>5</b>	<b>Diet and Exercise</b>		<b>What type of diet do you have?</b>	
	<b>How much exercise do you do?</b>		<input type="checkbox"/> Healthy	
	<input type="checkbox"/> Sedentary (No exercise)		<input type="checkbox"/> Unhealthy	
	<input type="checkbox"/> Gentle (climbs stairs, walking , gardening)		<input type="checkbox"/> Vegan	
	<input type="checkbox"/> Moderate (Cycling, swimming regularly)		<input type="checkbox"/> Vegetarian	
	<input type="checkbox"/> Vigorous (Attends gym regularly)		<input type="checkbox"/> Moderate	
	Please enter your height in		Please enter your weight in	
Feet / inches:	cm:	Kilos/grams:	Stones / lbs:	

**6 Lifestyle**

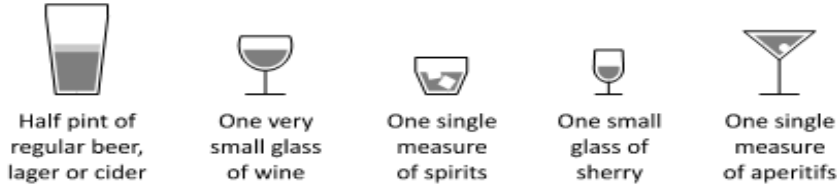
Are you currently a smoker?  Yes  No  
 Have you ever been a smoker?  Yes  No

If you smoke, how many Cigarettes / Cigars / Tobacco do you smoke in a day?

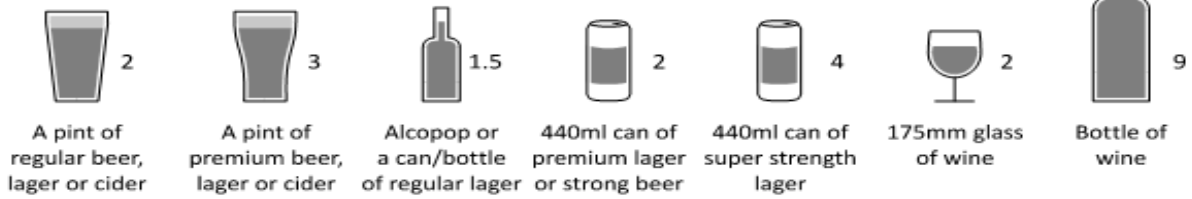
If you are a smoker and want to STOP please tick here:

**Alcohol** Alcohol consumption is measured in units, which is explained in the diagram below.

This is **one unit**...



...and each of these is **more than one unit**...



Please have a look at the above diagram and then answer the questions on the next page.

**Total AUDIT Score (Questions 1 – 10):**

Questions about your Alcohol Consumption	Scoring System					Your score
	0	1	2	3	4	
1. 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	
2. 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+	
3. 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	
<b>If your total score for the above 3 questions is 4 or less, then you do not need to complete the questions below</b>						
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence.



<b>7</b>	<b>Women Only</b>	What is the date of your last <b>Smear test</b> ? (Also known as a <b>PAP</b> or <b>Cervical smear</b> )		Date:	Result:
	Was this at your GP Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please specify who processed your <b>Smear test</b> :		<input type="checkbox"/> NHS <input type="checkbox"/> Private <input type="checkbox"/> Abroad
	Date of last <b>Mammogram</b> (if applicable):				
	Number of <b>pregnancies</b> (include miscarriages & terminations) (If applicable)				
	Do you wish to see a doctor in this Practice for contraceptive services (including the pill, coil or cap)?				

<b>8</b>	<b>Your Medical Background</b>				
	Are there any serious diseases that affect your parents, brothers or sisters? Tick all that apply <u>and</u> state family member:				
	<input type="checkbox"/> <b>Diabetes</b> Who:	<input type="checkbox"/> <b>Asthma</b> Who:	<input type="checkbox"/> <b>Thyroid disorder</b> Who:	<input type="checkbox"/> <b>Stroke</b> Who:	<input type="checkbox"/> <b>COPD</b> Who:
	<input type="checkbox"/> <b>Heart Attack</b> under age of 60 Who:	<input type="checkbox"/> <b>Cancer</b> (Specify type) Who:	<input type="checkbox"/> <b>High Blood pressure</b> Who:	Any other important family illness. Please state:	Who:
<b>Do you suffer from any of the following chronic conditions?</b>					
<b>Chronic condition</b>	<b>Date of diagnosis</b>	<b>Medicines you are currently taking</b>	<b>Staff use only</b>		
Diabetes Mellitus Type I			X40J4		
Diabetes Mellitus Type II			X40J5		
Stroke			XaEGq		
Ischaemic Heart Disease			XE2uV		
Hypertension			XE0Ub		
Emphysema			H32..		
Chronic Bronchitis			H31..		
Asthma			H33..		
Chronic Kidney Disease			X30In		
Depression			XaB9J		
Schizophrenia			Eu20z		
Bipolar Disorder			X00SM		
Other (please state):					

Please state any allergies and sensitivities you have to medicines, food & dressings:	<b>PLEASE ENTER NOMINATED PHARMACY:</b>		
Please state any mental disabilities you have:			
Are you able to administer your own medicines?	<input type="checkbox"/> Yes <input type="checkbox"/> No <b><i>If no</i></b> please give details, e.g. swallowing or opening containers:		
What long term medical conditions have you had?	Date of Diagnosis:		
What operations or serious injuries have you had?	Date of operations or injuries:		
Please list any tablets, medicines or other treatments you are currently taking / undertaking not already mentioned:			
<b>Name of medication?</b>	<b>What condition is it for?</b>	<b>How many do you take and how often?</b>	<b>What is the dose/strength?</b>

**VISITORS AND STUDENTS COMING TO THE UK**  
**Contract agreement with the Practice**

This is an agreement between the Patient (Visitors/Students) and the practice.

We will accept visitors/Students to register with the practice that provides full visa statement and proof of documentation and are living in our catchment area.

**Patients Responsibility**

- Provide copies of your visa status documentation/Passports
- Visa extension – proof of documentation with visa dates
- Inform the practice when you are due to return back to your country

I agree that copies and details of documentation mentioned above details are all correct and confirm that I fully understand that I will be removed from the practice list without any reminders on the date my visa expires/date of departure. It will be my responsibility to inform the practice of any extension to my stay before the visa expiry date/date of departure.

Visa Expiry Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Sign: \_\_\_\_\_

Date: \_\_\_\_\_

<b>9</b>	<b>Sharing Your Medical Record</b>
<p><b>Medical Record Sharing:</b> Allows your complete GP medical record to be made available to authorised healthcare professionals involved in your care. You will always be asked your permission before anybody looks at your shared medical record.</p> <p><b>If you do want to share your GP record tick here:</b> <input style="float: right;" type="checkbox"/></p> <p><b>If you do not want to share your GP record tick here:</b> <input style="float: right;" type="checkbox"/></p>	
<p><b>Summary Care Record:</b> Contains details of your key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&amp;E Departments throughout England. You will always be asked your permission before anybody looks at your Summary Care Record. Ask your GP about the optional ‘Additional information’ choice.</p> <p><b>If you do want to have a Summary Care Record created tick here:</b> <input style="float: right;" type="checkbox"/></p> <p><b>If you do not want to have a Summary Care Record tick here:</b> <input style="float: right;" type="checkbox"/></p>	

<b>10</b>	<b>Patient Participation Group (PPG)</b>
<p>The Practice is committed to improving the services we provide to our patients. To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better. By expressing your interest, you will be helping us to plan ways of involving patients that suit you. It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.</p> <p>If you are interested in getting involved in the PPG, please tick yes in the box below and we will contact you with further details.</p>	
<p><b>Yes</b> I am interested in becoming involved in the PPG <input type="checkbox"/>      <b>No</b> I am not interested in becoming involved in the PPG <input type="checkbox"/></p>	

<b>11</b>	<b>Online Services</b>
<p>You can now do the following online or via the SystmOnline app:</p> <ul style="list-style-type: none"> <li>• Book and cancel appointments, order repeat prescriptions, view your Detailed Medical Record.</li> </ul> <p style="text-align: center; font-size: small;">IT WILL BE YOUR RESPONSIBILITY TO KEEP YOUR LOGIN DETAILS AND PASSWORD SAFE AND SECURE. IF YOU KNOW OR SUSPECT THAT YOUR RECORD HAS BEEN ACCESSED BY SOMEONE THAT YOU HAVE NOT AGREED SHOULD SEE IT, THEN YOU SHOULD CHANGE YOUR PASSWORD IMMEDIATELY.</p>	
<p><b>Yes</b> I'd like to register for online services <input type="checkbox"/>      <b>No</b> I don't want to register for online services <input type="checkbox"/></p>	
<p>We can now send your prescriptions electronically to the pharmacy of your choice. If you would like us to do this, please give the name and location of the pharmacy here:</p>	

<b>12</b>	<b>Other Information</b>	
<p>Do you have a <b>“Living Will”</b> or <b>“Advanced Directive”</b>? (A statement explaining what medical treatment you would not want in the future)?</p>		<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If “Yes”, can you please bring a written copy of it to your first appointment?</b></p>
<p>Have you nominated someone to speak on your behalf (<i>e.g. a person who has Lasting Power of Attorney</i>)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>		<p><b>If “Yes”, please state</b> their</p> <p>Name: Address: Phone number:</p>



<b>13</b>	<p><b>NHS (Charges to Overseas Visitors) Regulations 2015 Self Declaration</b></p> <p>I am a British resident and entitled to full NHS care <input type="checkbox"/></p> <p>I hold a non-UK issued European Health Insurance Card (EHIC) <input type="checkbox"/></p> <p>I hold an S1 form (entitlement to health care in another European Economic Area country for a limited duration) <input type="checkbox"/></p> <p>For more information on your entitlement to NHS care and charges which may be applicable, please talk to your practice for a leaflet explaining the rules and entitlements for overseas patients accessing the NHS in England.</p>
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<b>14</b>	<p><b>NHS Health Check for patients aged 40-74 years old ("Health M.O.T")</b></p> <p>The NHS Health Check is a health check-up for adults in England aged 40-74. It is designed to spot early signs of stroke, kidney disease, heart disease, type 2 diabetes or dementia. As we get older, we have a higher risk of developing one of these conditions. An NHS Health Check helps find ways to lower this risk.</p> <p>If you are in the 40-74 age group without a pre-existing condition and you have not had a free NHS Health Check for the past five years you are eligible for an appointment.</p> <p>Please tick if you would like the surgery to contact you for a free NHS Health Check appointment <input type="checkbox"/></p>
<b>15</b>	<p><b>NHS Blood Donor Registration</b></p> <p>To register yourself as a NHS Blood Donor please log on to <a href="http://www.blood.co.uk/giving-blood">http://www.blood.co.uk/giving-blood</a></p> <p>Or contact Give Blood Helpline on 0300 123 23 23.</p>

**Patient records are held on the computer as well as paper. GPs are responsible for the confidentiality of these records. On occasion, we share information from the patient records with the Health Authority, NHS England, CCG, hospitals and other NHS/partner organisations in the interest of patient care. If required please obtain a confidentiality leaflet from reception.**

**RIGHTS AND RESPONSIBILITIES FOR PATIENTS AND THE PRACTICE**

We believe that the practice and patients both have rights and responsibilities to ensure a friendly, courteous and efficient service provided under a safe environment. Below are some responsibilities that patients and the practice should always follow.

- Patients
- You have the right to a full explanation of your illness and any tests, investigations or consultations relating to that illness.
  - If you require a referral to a specialist you will be offered choice, in accordance with the NHS 'Choice and Booking' agenda.
  - You should treat the doctor, nurse and other staff members and patients with courtesy and respect at all times.
  - As this is a busy practice, please be patient if the doctor/nurse is running late.
  - Please note that it is not our policy to provide housing and social needs letters to patients. Such letters are only provided when requested by an office body i.e. The council, Social services.
  - All non-NHS services will incur charges depending on the service requested, please confirm the agreed fee with staff before proceeding with your request. Any private report etc. is provided on the basis of your medical conditions and fees are charged in respect of time spent preparing such reports, therefore fees are non-refundable.
  - Please note that first seven days of any sickness a self-certificate (SC2) is sufficient. However, if requested a private certificate may be issued and appropriate fee charged.
  - 48 hours notice is required for all repeat prescriptions. Requests for repeat medication are not normally accepted over the phone. Please use a SAE or attend the surgery in person. All repeat medication should be ordered in advance and not when you have run out. Repeat medication will only be issued when due, in accordance with the dose indicated by your doctor.
  - Please ensure a single appointment is for one person and one or two problems only. If you have more than two medical problems please inform the receptionist when booking your appointment.
- Practice
- Everyone attending the practice is to be treated with respect and courtesy at all times, irrespective of his/her ethnic origin, religious beliefs, personal attributes, or the nature of health problem.
  - We will maintain your right to privacy and confidentiality and will not discuss your illness with other staff members on an unprofessional basis.
  - We maintain the right to remove patients from our list who display unacceptable behaviour or violence towards staff or other patients.
- Please sign below if you accept these terms and conditions.

Patient's signature.....

Date.....

**CHECKLIST**



Thank you for completing this form. Please check you have completed all sections where possible  
Please ensure that you bring the following with you to the surgery to complete your registration:

1. **Completed & Signed New Patient Registration Questionnaire** (this form!)
2. **Completed & Signed GMS1 Form**
3. **Photo Proof of ID** - e.g. Passport, Photo Driving License or Photo ID card, birth certificate for new born
4. **Proof of Address – *Must be in your name and dated within the past 3 months***   
 – *Provided in one of the following:* Bank statement, Utility Bill (Gas, Electricity, Water), Council Tax, Tenancy Agreement or Landline Phone Bill (Mobile phone bills are not accepted)
5. If possible, your **Immunisation Records** – usually the Personal Child Health Record (“Red Book”)
6. If possible, your **NHS Card** – usually shows your previous GP and your NHS Number
7. If relevant, your **Repeat Medication Request Slip** from your previous GP

- Please book a **New Patient appointment** if you are on any regular medication or have any chronic or significant medical condition
- Please request a copy of the Practice Leaflet if you have not already received it. Alternatively you can also find more information on our practice website
- I confirm that I have completed this form as accurately and honestly as possible and would like to apply to be registered as a patient at this practice

<b>16</b>	<b>Signature</b>	<b>Date:</b>
	<b>Patient signature:</b>	<b>Signature if signing on behalf of patient:</b>

**Surgeries providing the Weekend Plus Service**

**Brook Green Medical Centre Bute Gardens, London, W6 7EG**

**Opening Times:**

**Mon – Fri-18.30 – 20.00 Sat & Sun- 08:00-20:00**

**Parkview (Dr Canisius & Dr Hasan) Parkview, Practice Parkview, Centre for Health & Wellbeing, Cranston Court 56 Bloemfontein Road, W12 7FG**

**Opening Times:**

**Mon – Fri 18.30 – 20.00 Saturday 9.00 – 17.30 Sunday 9.00 – 13.00**

**Cassidy Medical Centre, 651A Fulham Road, SW6 5PX**

**Opening Times:**

**Mon-Fri- 18.30 – 20.00 Sat & Sun- 09:00-15:00**

<b>OFFICE USE ONLY</b>	Need Appt? <input type="checkbox"/> Yes <input type="checkbox"/> No	Need Etoh Advice? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Staff Initials:</b>
Photo ID	<input type="checkbox"/> Passport <input type="checkbox"/> Driving licence	<input type="checkbox"/> Identity card	<input type="checkbox"/> Other
Proof of Address	<input type="checkbox"/> Utility Bill <input type="checkbox"/> Tenancy Agreement	<input type="checkbox"/> Bank Statement	<input type="checkbox"/> Other
Nominated GP	<input type="checkbox"/> Patient advised <input type="checkbox"/> Patient not advised (add reminder to record)		