Newbury Group Practice

**New patient registration document**

**Please note : All people wishing to register with the practice must attend the surgery in person**

**PROOF OF ADDRESS WHAT WE CAN ACCEPT (All should be dated within 3months of registration & only original documents sent to address )**

* Recent utility bill or statement
* Local authority tax bill **(current year)**
* Bank or building society statements **(not online copy)**
* Local council rent card
* Tenancy agreement
* Solicitors letter confirming recent purchase of patient property
* Letter from tax office **(needs to be dated)**
* Job seeker benefit letter **(needs to be dated)**
* University/College/School letters **(needs to be dated)**

**PROOF OF PHOTO ID (Including full name as registering)**

* Passport/Birth Certificate (Adults) **AND** Red book or immunisation book (Children under 6 years only and NHS number)
* Provisional/Full license
* EU/EEA member state identity card
* Blue disabled driver pass
* Current EU/EEA driving license
* Oysters (only if it has name printed on) (Freedom Pass)
* Resident Card – biometric card
* Student/NUS Card
* Employee ID

If you are unable to provide any of the above documents please speak to a member staff reception team who will be able to discuss alternative documents

Office Use Only

**Proof of ID**

 **Take copy and attach**

**Proof of Address**

**Name of institution ………………………………..**

**Date of document …………………………………..**

Staff member name ………………………………….

* If no previous address ask for date of entry to UK
* Need full address and previous GP address/name
* When registering baby ensure mother is registered and write her name on document

**ENSURE there is a contact number and all information is legible**

Newbury Group Practice

Do you have any special communication needs? 🞏 Yes 🞏 No

If yes: 🞏 Sign Language 🞏 Large Print 🞏 Other …………………………………………………………….

**CONFIDENTIAL MEDICAL REGISTRATION FORM**

**Please complete all \* asterix & please complete pages in FULL using BLOCK capitals**

Surname\*

First Names (in full)\*

Previous Surnames\*

Title **\***: 🞏 Mr 🞏 Master 🞏 Mrs 🞏 Miss 🞏 Ms 🞏 Male 🞏 Female

Date of Birth (day/month/year)\* NHS Number***\****

Town & country of Birth\*

 Post Code:

Current Address\*:

Your previous address in the

 Post Code:

UK\*

Telephone number\*: Mobile number:

Email address\*:

**If you are from abroad:**

If previously resident in UK Date you first

date of leaving \* came to UK\*

 (Day/Month/Year)

**Please help us trace your previous medical records by providing the following information:**

Name of previous Doctor

while at previous address\*

 Post Code:

Address of previous Doctor\*

Where did you last receive Date:

treatment?\*

*ie GP, Walk in Centre, MIU, Emergency Department etc*

What was the outcome of

this visit? ie prescription\*

**If you are returning from the Armed Forces:**

Addresss before enlisting

 Post Code:

Enlistment date Service/

 Personnel number

**NHS Organ Donor registration:**

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

🞏 Any of my organs and tissue or

🞏 Kidneys 🞏 Heart 🞏 Liver 🞏 Corneas 🞏 Lungs 🞏 Pancreas 🞏 Any part of my body

Signature to confirm agreement to organ/tissue donation is at the bottom of this form.

For more *information please visit the website* [*www.uktransplant.org.uk*](http://www.uktransplant.org.uk) *or call 0300 123 23 23*

Signature\*: …………..………………………………………………………………… Date\*: ………………….

**NHS Blood Donor registration:**

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood. Tick here if you have given blood in the last 3 years 🞏

Signature to confirm consent to inclusion on the NHS Blood Donor Register at the bottom of this form.

*For more information, please ask for the leaflet on joining the NHS Blood Donor Register. My preferred address for donation is (only if different from above eg your place of work)*

Signature\*: …………..………………………………………………………………… Date\*: ………………….

**Please tell us about yourself:**

Are you a carer\*? 🞏 Yes 🞏 No Do you have a carer\*? 🞏 Yes 🞏 No

If yes, please tell us the name & address of your

Carer:

Are you happy for us to contact your carer 🞏 Yes 🞏 No

about you?

**For patients aged 85 or over: (these are to help us assess if you may need additional clinical input)**

In general, do you have any health problems that require you to limit your activities?  🞏 Yes 🞏 No

In general, do you have any health problems that require you to stay at home?   🞏 Yes 🞏 No

Do you regularly use a stick, walker or wheelchair to get about?     🞏 Yes 🞏 No

In case of need, can you count on someone close to you?    🞏 Yes 🞏 No

Do you need someone to help you on a regular basis?    🞏 Yes 🞏 No

Please provide details if the person is different

from the information you have provided as your career.

**Personal Medical History…..**

Have you ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

|  |  |  |
| --- | --- | --- |
| **Condition** | **Year diagnosed** | **Ongoing**  |
|  |  | Yes/No |
|  |  | Yes/No |
|  |  | Yes/No |

**Family History…..**

Have any close relatives (*father, mother, sister, brother only*) ever suffered from any of the following: (please indicate who in the boxes)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Heart attack | Stroke | Diabetes | High blood pressure | Asthma | Glaucoma | Cancer |
|  |  |  |  |  |  |  |

**Immunisations ……**

|  |  |  |  |
| --- | --- | --- | --- |
| **Immunsation** | **Year** | **Immunisation** | **Year** |
| Tetanus |  | Polio |  |
| Typhoid |  | Yellow Fever |  |
| Hepatitis A |  | Hepatitis B |  |

**Allergies ……**

Please list any allergies you have to any drugs/medication:

|  |  |
| --- | --- |
| **Name of medication** | **What was the problem or upset?** |
|  |  |
|  |  |

If you have a copy of your repeat medications, please pass to Reception to copy

**List of current medication ……**

|  |  |
| --- | --- |
| **Name of medication**  | **Dosage** |
|  |  |
|  |  |

**Lifestyle ……**

Please enter your height & weight:

|  |  |
| --- | --- |
| Height: | Weight: |

**Lifestyle smoking ……**

Do you smoke: 🞏 Yes 🞏 No If yes, do you

smoke: 🞏 Cigarette 🞏 Cigars 🞏 Pipe

Are you an ex-smoker? 🞏 Yes 🞏 No When did you give up?

How many cigarettes/ 🞏 <1/day 🞏 1-9/day 🞏 10-19/day 🞏 20-39/day 🞏 40+/day

cigars do you smoke

daily?

If you smoke a pipe Would you like help 🞏 Yes 🞏 No

how many ounces a to quit smoking?

week?

**Lifestyle alcohol ……**

**OVER 18 YEARS OLD ONLY**

Do you drink alcohol: 🞏 Yes 🞏 No If yes, please answer the following questions:

How many units do you have on a typical day that contain alcohol?

🞏 **1 unit** = A small bottle of alcopop **(275ml),** Half pint of beer or cider **(4%)**, A single measure of spirit **(40%)**

🞏 **2 unit** = A standard glass of wine or champagne **(175ml)**, A pint of lower strength of large beer or cider **(4%)**, A can medium strength of beer or cider **(440ml)**, A double measure of spirit **(40%)**

🞏 **3 unit** = A pint medium strength of large beer or cider **(5%)**, A large glass of low strength **(250ml)**, A large bottle of alcopop **(750ml)**

🞏 **4** **unit**= A large bottle higher strength of alcopop **(750ml)**,A large higher strength can of beer or cider **(500ml)**

🞏 **5** 🞏**6** 🞏**7** 🞏**8** 🞏**9** 🞏**10** 🞏**11** 🞏**12+ or more**

**Lifestyle exercise ……**

Do you exercise: 🞏 Yes 🞏 No If yes, please answer the following questions

What exercise do you do?

How often do you exercise?

**Female patients only ……**

**vej**

Are you currently, or think you may be 🞏 Yes 🞏 No

pregnant?

Do you have any children? 🞏 Yes 🞏 No If yes, how many?

Which method of contraception (if any) are

you using at present?

Have you had a cervical smear test? 🞏 Yes 🞏 No If yes, what was the

 result? (if known)

 Date (if known)

**Ethnicity\* ……**

**vej**

Please indicate your ethnic origin:

🞏 British or mixed British 🞏 Irish 🞏 African 🞏 Caribbean 🞏 Sikh 🞏 Indian 🞏 Pakistani

🞏 Bangladeshi 🞏 Chinese 🞏 Romanian 🞏 Polish 🞏 Sri Lanka 🞏 Decline to state 🞏 Other:

**Next of kin\* ……**

**vej**

Title: Full name: Gender: 🞏 Male 🞏 Female

Tel. contact number:

Relationship:

**Data sharing consent choices\*..…**

**vej**

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). For further information please request the leaflet which details what part of your record is extracted and how it is used to help other NHS organisations.

If you wish to **OPT OUT** please request and complete the form from reception.

Where you have provided information on how to contact you, can you confirm you are happy for [insert name of practice] to contact you by the following:

By email 🞏 Yes 🞏 No This will be to send you letters, newsletter and

 the like

By text 🞏 Yes 🞏 No This will be to send you reminders of

appointments via text

**Signature\* ……**

**vej**

I confirm that the information I have provided is true to the best of my knowledge.

Signed\*: Date\*:

Signature of patient\* 🞏 Signature on behalf of patient\* 🞏

**ELECTRONIC PRESCRIPTION CONSENT FORM**

**PATIENT NAME:**

**PATIENT ADDRESS:**

**NHS No: D.O.B:**

**CONTACT NO:**

**GENDER: MALE FEMALE**

**PHARMACY ADDRESS:**

**PATIENT SIGNTAURE: DATE:**

**RESPENTATIVE NAME:**

**RESPENTATIVE SIGNTAURE:**