Dog Kennel Lane Surgery New Patient Registration Form

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| **Today’s Date:**  Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice). The information will help us to provide better and more comprehensive care for you. When you register you will be allocated a named accountable GP, although this will not restrict which GP you can see. You will also be offered a ‘New Patient Appointment’ with a Practice Nurse. Please bring a urine sample with you for your appointment.  Please complete in BLOCK CAPITALS and tick the boxes as appropriate.  Please bring your driving licence/passport to confirm your address and date of birth.  Please complete a separate form for each family member to be registered. | | | | | | | | | | | | | | | |
| Full Name: | | | | | | | | | Telephone Number: | | | | | | |
| Mr / Mrs / Miss / Ms / Other…….. | | | | | | | | | Work Number: | | | | | | |
| Address and post code: | | | | | | | | | Mobile Number:  Are you happy to receive text messages?  **Yes / No** | | | | | | |
| Email address: | | | | | | |
| Date of Birth: | | | Previous/ Mother’s Surname if different: | | | | | | Town & Country of Birth: | | | | | | |
| Marital Status: | | | Gender:  M / F | | | Other, please state: | | | NHS Number if known: | | | | | | |
| If applicable, date you first came to live in Britain: | | | | | | | | |  | | | | | | |
| If returning from Armed Forces: | | | | | | Your Service or Personnel Number: | | | | | | Your Enlistment Date: | | | |
| Next of Kin: | | | | | | | | | | | | Next of Kin Contact Number: | | | |
| Your  Religion: | | Hindu | | | Muslim | | C of E | Other Christian (state) | | | Buddhist | | | Catholic | |
| Sikh | | | Jewish | |  | Jehovah’s Witness | | | No Religion | | | Other Religion: (state) | |
| Your Ethnic Origin: (select one) | | | | White (UK) 9S1 | | | | | White (Irish) XaFwE | | | | White (Other) XaFwF | | |
| Caribbean XaJR6 | | | | African XaJR7 | | | | | Asian XaFwz | | | | Other Mixed Background XaJR1 | | |
| Indian / Brit Indian XaJR2 | | | | Pakistani / Brit Pakistani XaJR3 | | | | | Bangladeshi / Brit Bangladeshi XaJR4 | | | | Other Asian Background XaJR5 | | |
| Your main or 1st language Spoken / Understood: (select one) | | | | English | | Hindi | | | Gujurati | Urdu | | | Bengali /Sytheti | | Punjabi |
| Polish | Ukrainian | | | French | | German | | | Spanish | Other: (Please Specify) | | | Other: Please specify | | |
| **WE ARE UNABLE TO SPEAK TO ANYBODY ON YOUR BEHALF WITHOUT YOUR CONSENT**  **IF YOU WISH TO HAVE SOMEBODY NAMED ON YOUR MEDICAL RECORD TO SPEAK ON YOUR BEHALF**  **YOU MUST COMPLETE AND SIGN A CONSENT FORM – PLEASE ASK RECEPTION FOR A FORM** | | | | | | | | | | | | | | | |
| |  |  |  |  | | --- | --- | --- | --- | | Your Medical Background: | | | | | Have you ever suffered from any of the following? | | | | | Condition | Yes | No | Approximate date condition started | | Epilepsy |  |  |  | | Blindness / Glaucoma |  |  |  | | Blood Pressure |  |  |  | | Diabetes |  |  |  | | Stroke / TIA |  |  |  | | Heart Attack |  |  |  | | Asthma |  |  |  | | Eczema |  |  |  | | Cancer (breast/bowel/lung/other) |  |  |  | | Allergic to penicillin |  |  |  | | Other allergies |  |  |  | | Medications | If you are currently taking any medications, please provide us with a copy of your **repeat prescription slip** so that we can ensure there is no interruption to your supply of medication. | | | | Are you able to administer your own medication? | **Yes/No** | **If ‘NO’ please details specific issues (e.g. swallowing, opening containers)** | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | Are there any serious diseases that affect your parents, brothers or sisters (tick all that apply) | Diabetes | Heart attack | Heart attack UNDER the age of 60 | Bowel Cancer | | Breast Cancer | High blood pressure | Asthma | Stroke | | Thyroid disorder | Any other important family illnesses? | | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | What immunisations have you had? (please tick all that apply) | Diphtheria | Measles | German Measles | Tetanus | Polio | MMR | | Whooping Cough | | Pre school booster | | Triple vaccine (Diphtheria, tetanus and pertussis) – 3 doses | |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Smoking, Alcohol Consumption and Exercise: | | | | | | | | Are you currently a smoker? | Yes  137R | No | If no, have you ever been a smoker | | Yes  Ub1na | No  XE0oh | | If so, how many cigarettes / cigars / tobacco do you smoke in a week? | |  | ***If you are a smoker and want to stop, please ask for information about local smoking cessation services*** Ua1Nz | | | | | How often do you exercise? | Number of times per week? | | Type(s) of exercise |  | | |   Tools | Alcohol IBA blog   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **Specific needs:**  **Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:** | | | | | | | | | | Please state any sensory impairment you may have (i.e. speech, hearing, sight) | |  | | | | | | | | Do you have any communication or information needs relation to a disability or sensory loss? | |  | | | If yes, please specify your needs: | |  | | | Are you an ‘Assistance Dog’ user? | |  | | | | | | | | Please state any physical disabilities you have: | |  | | | | | | | | Please state any mental disabilities you may have: | |  | | | | | | | | Please state any requirements you have to be able to access the Practice premises: | |  | | | | | | | | Please state any religious or cultural needs: | |  | | | | | | | | Do you require the help of a translator / interpreter? | |  | | | | | | | | Please state any specific nutritional requirements you have: | |  | | | | | | | | If you are a carer, please state the name / address / phone number of the person you care for: | | **Person cared for contact details** | | | | | | | | If you have a carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your carer: | | **Carer contact details** | | | | | | | | Signed: | | | | | Date: | | | Do you have a ‘ Living Will’ ( a statement explaining what medical treatment you would not want in the future)? | | Yes / No | | | | If ‘YES’,  Can you please bring a written copy of it to your New Patient Consultation | | | | Have you nominated someone to speak on your behalf (e’g a person who has Power of Attorney)? | | Yes / No | | | If ‘YES’ please state their name / address / telephone number | | | | | Women only: | | | | | | | | | | When was your last smear done? | Date | | | Was this at you GP Surgery | | | Yes | No | | What was the result of the smear? |  | | | | | | | | | Date of last mammogram? |  | | Method of contraception, if used? | | | |  | | | Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap?) | | | | | | | Yes | No |  |  | | --- | | **Summary Care Records:**  The NHS are changing the way your health information is stored and managed. The NHS Summary Care record is an electronic record of important information about your health. It will be available to health care staff providing your NHS Care.  Are you happy to have a Summary Care Record? Yes / No |   **Preferred method of communication**: Please tick as appropriate  No preference:  Written:  Telephone:  Please add preferred telephone number:  SMS:  Please add current up to date mobile number:  Email:  Please Add current up to date email:  Sign Language:  **Patient Sharing Data Consent :**  **Sharing out**: Do you, the patient consent to the sharing of data recorded here with any other organisations that may care for you, the patient (such as referrals to hospital)  **Yes – share data with other organisations**  **No – do not share any data recorded here**  **Sharing in –** Do you, the patient consent to the viewing of data by this organisation that is recorded at other care services that may care for you, the patient where the patient has agreed to make the data shareable?  **Yes - Consent given**  **No - Consent refused**  **Do you wish to have a person to speak on your behalf regards your medical record? If so, please complete the consent form attached, as appropriate.**  **DOG KENNEL LANE SURGERY**  PATIENT CONSENT FORM –**MEDICAL RECORD**   |  |  | | --- | --- | | Patient full name including title  Mr / Mrs /Miss /Ms / Mx / other – please state |  | | Patient date of birth: |  | | Patient address: |  | | Patient email address: |  | | Patient contact number: | Home:  Mobile: | | I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give consent for the person stated below to discuss  my medical record from the date that this has been signed below.  PLEASE STATE ANY RESTRICTIONS HERE REGARDS INFORMATION SHARED: | | | Patient signature: |  | | Date: |  | | Name of person to speak on behalf of patient:  Mr / Mrs /Miss /Ms / Mx / other – please state |  | | Contact details of person to speak on behalf of patient: | Home:  Mobile: |  |  | | --- | | **The security of the information we hold about you is very important to us. Further information on how we process, store and share your data can be found in our leaflet ‘How we use your information’ and in our ‘Data Protection Privacy Notice’ available at reception** |  |  |  | | --- | --- | | **Patient Participation Group**  **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 suits you. It will also mean that we can keep you informed of opportunities to give your views and up to date with developments within the Practice.**  **If you are interested in getting involved, please tick the box below and we will contact you regards applying.** | | | **Yes, I am interested in becoming involved in the Practice Participation Group (Please tick the YES box)** | **YES** |  |  |  |  |  | | --- | --- | --- | --- | | Patient Signature: |  | Signature on behalf of patient: |  | | Your physical examination will include having your height, weight and blood pressure taken and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice). The consultation will also establish relevant past medical and family history, including:   * Medical factors – illnesses, immunisations, allergies, hereditary factors, screening tests, current health * Social factors – employment, housing, family circumstances * Lifestyle factors – diet and exercise, smoking, alcohol and drug abuse | | | |  Thank you for completing this form. | | | | | | | | | | | | | | | |