New Patient Registration Form (Adult: 16 and over)

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

Date ……

1	**Full Name:**				**Date of Birth:**
	Title : ☐ **Mr**	☐ **Mrs**	☐ **Miss**	☐ **Ms**	**Gender:** ☐ **Male** ☐ **Female** ☐ **Other.** *Please state* **:**
	Other. *Please state* **:**				**Marital Status:**
	Mobile tel. number: We will use this to send appointment reminders and health promotion details. Please tick here to give your consent for this: ☐				**Maiden name / Mothers name if different:** **Current Address:**
	Work tel. number:				**E-mail address:**
	Next of Kin: **Relationship to Patient:**				**Next of Kin contact tel. number:**
	Town* and Country of birth **Country:** **Borough (*If born in London):** **(*If town is London please state which Borough) Town:**				
	Please list other relatives of your home who are registered with us:				
	Relationship:	**Name:**	**Date of Birth:**		

2	**Looking After Someone**	
	Are you looking after someone? 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.	☐ Yes ☐ No
	Is someone looking after you? 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.	☐ Yes ☐ No
	Carer's name :	**Relationship to you:**
	Address of carer :	
	Telephone number of carer :	

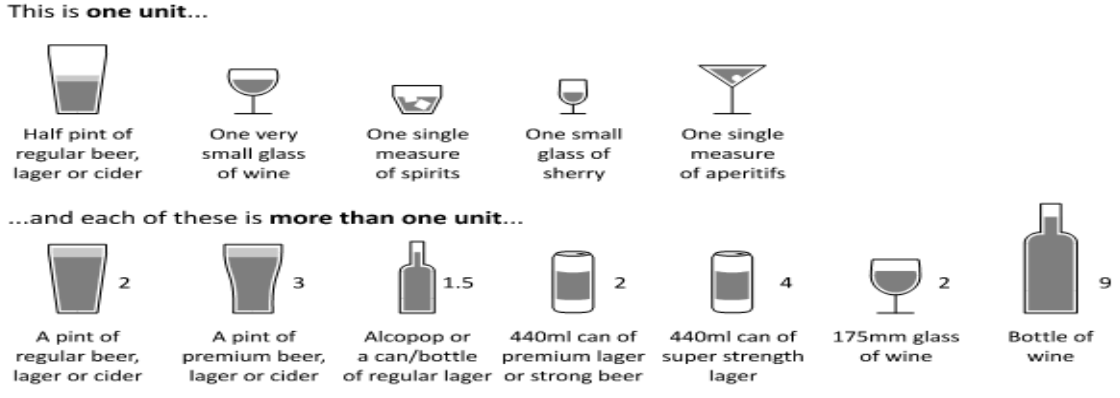
3	**Are You Currently Employed?**			
	If so please specify whether :	☐ **Full-time**	☐ **Part-time**	☐ **Self-employed**
	If you are not employed, please indicate which best describes you:			
	☐ **Retired**	☐ **Student**	☐ **Housewife/ Homemaker/House husband**	☐ **Unemployed**
	☐ **Other** ***Please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

4	Your Ethnic Origin			
	Please tick one:	☐ White (UK)	☐ White (Irish)	☐ White (Other)
	☐ Black Caribbean/British	☐ Indian/British Indian	☐ Arabic	☐ Other Mixed Background
	☐ Black African / British	☐ Pakistani ☐ British Pakistani	☐ Chinese	☐ Other Asian Background
	☐ Other Black Background	☐ Bangladeshi / British Bangladeshi	☐ Other	☐ Ethnic Category Refused
	What is your main spoken language? **Do you speak English?** Yes ☐ No ☐		**Do you need an Interpreter?** Yes ☐ No ☐	
	Do you need help with mobility/hearing/speaking? (tick all that apply)			
	☐ Wheelchair	☐ Walking aid	☐ Hearing aid	☐ British sign language (BSL) ☐ Makaton sign language
	☐ Lip reading	☐ Large print	☐ Braille	☐ Other. ***Please state***:
	Are you currently?	Homeless ☐	A Refugee ☐	An Asylum Seeker ☐
	Are you housebound?	Yes ☐ No ☐	Comments:	

Please state all countries you have lived in or visited for periods of greater than 6 months:	
Country: **If you are aged between 16-35 and been in England less than 5 years you may be offered a blood test for Tuberculosis**	**Dates/Year (If known):**

5	**Diet and Exercise**		**What type of diet do you have?**	
	How much exercise do you do?		☐ Healthy	
	☐ Sedentary (No exercise)		☐ Unhealthy	
	☐ Gentle (climbs stairs, walking , gardening)		☐ Vegan	
	☐ Moderate (Cycling, swimming regularly)		☐ Vegetarian	
	☐ Vigorous (Attends gym regularly)		☐ 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.		



Please have a look at the above diagram and then answer the questions below.

Questions	Scoring system					Your score
	0	1	2	3	4	
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 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	
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	
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	

7				
	Women Only	What is the date of your last ***Smear test***?	Date:	Result:
	Was this at your GP Surgery?	☐ Yes ☐ No	Date of last ***Mammogram*** (if applicable):	
	Number of ***pregnancies*** (include miscarriages & terminations) (If applicable)			

8					
	Your Medical Background				
	Are there any serious diseases that affect your parents or siblings? Tick all that apply *and* state family member:				
	☐ **Diabetes** Who:	☐ **Asthma** Who:	☐ **Thyroid disorder** Who:	☐ **Stroke** Who:	☐ **COPD** Who:
	☐ **Heart Attack under age of 60** Who:	☐ **Cancer (Specify type)** Who:	☐ **High Blood pressure** Who:	**Any other important family illness. *Please state***:	Who:
	Please state any allergies and sensitivities you have to medicines, food & dressings:				
	Please state any mental disabilities you have:				
	Are you able to administer your own medicines?	☐ Yes ☐ No	***If no*** 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:				
	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: Please let us know each time you request your prescription whether you would like it to go to this pharmacy or collect from the practice.				

9	**Sharing Your Medical Record**
	Medical Record Sharing 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. **If you don't want to share your GP record tick here:** ☐
	Summary Care Record contains details of your key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. You will always be asked your permission before anybody looks at your Summary Care Record. **If you don't want to have a Summary Care Record tick here:** ☐
	The Care.data Programme Collates information about you and the care you receive. It links information from all the different places where you receive care, such as your GP, hospital and community services, to help them provide a full picture of your medical needs and the care you are receiving. This data is made available to NHS Commissioners so that they can design integrated services and is shared with third parties for research purposes. **I wish to OPT OUT from my Personal Confidential Data being shared outside my *GP practice*:** ☐ **I wish to OPT OUT from my Personal Confidential Data being shared with *third parties*:** ☐

10	**Patient Participation Group (PPG)**	
	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. 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.	
	Yes I am interested in becoming involved in the PPG ☐	***No*** I am not interested in becoming involved in the PPG ☐

11	**Online Services**	
	You can now do the following online or via the SystmOnline app: • Book and cancel appointments, order repeat prescriptions, view your Detailed Medical Record. **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.**	
	Yes I'd like to register for online services ☐	***No*** I don't want to register for online services ☐

12	**Other Information**		
	Would you like to receive a Chlamydia screening test? ☐Yes ☐No Would you like to receive an HIV screening test? ☐Yes ☐No		
	Do you have a "***Living Will***" or "Advanced Directive"? (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 first appointment?
	Have you nominated someone to speak on your behalf (***e.g. a person who has Lasting Power of Attorney***)? ☐Yes ☐No	***If "Yes", please state*** their Name: Address: Phone number:	

13	**PATIENT/PRACTICE AGREEMENT**
	APPOINTMENTS: I agree to attend on time for all appointments and to cancel any appointment I cannot attend. I acknowledge that if I arrive more than 10 minutes late I will be asked to re-schedule. If you fail to attend 3 appointments (including hospital, physiotherapy, osteopathy or counselling) this will result in your name being removed from the GP's list. An appointment reminder will be sent to your mobile telephone number unless you have dissented to receiving text messages. **OUT OF HOURS SERVICE:** I agree to avail of the out of hour's service ONLY where it is medically necessary. For all other matters please call the surgery during opening hours or 111. **MOBILE PHONES:** I agree to SWITCH OFF my mobile phone BEFORE entering the practice and keep it switched off until I leave the building. **REPEAT PRESCRIPTIONS:** Please always use the computer request slip – either by hand, fax, email or post (please include SAE if it

is to be posted). The slip has your unique personal code and states the drugs which can be re-issued, if it is not on this slip it is not an agreed repeat medication. We do not take telephone requests. Anyone on repeat medications will be required to come in for a periodic review.

PRIVATE PRESCRIPTIONS: If we refer you to a private consultant and he instigates a medication, as long as we have a letter from him we will prescribe it for you. We do not convert private prescriptions to NHS under any other circumstances.

PATIENT'S WITH PRIVATE GP'S TRANSFERRING TO THIS PRACTICE: If you were previously registered with a private GP, we will need a letter from him stating your medical history and any medications you are taking. Without this information we will be unable to register you. The Practice will only prescribe medicines that have been recommended by a specialist following a referral by the Practice and will not continue any medicines on direction from a private GP. Please note that the Practice believes that it is in your best interest to have one primary care doctor and if we become aware that you are receiving treatment from another GP the Practice will communicate requesting clarification and then remove you as a registered patient.

TRAVELLING ABROAD FOR EXTENDED TRIPS: We do not supply medications for extended trips abroad.

ELIGIBILTY TO ACCESS THE NHS: Please note that being registered with The Chelsea Practice, and having a NHS number, does not give you automatic entitlement to access NHS Hospital treatment. Your eligibility to Hospital treatment will be determined by NHS England's governing body.

TREATMENT OF STAFF: We adhere to NHS zero tolerance of abuse towards staff. Any abusive, threatening or otherwise aggressive behaviour with any member of staff will result in removal from the list.

Please note that your named GP is Dr Scudder. This does not prevent you from seeing other GPs in the practice.

13	**Signature**	**Date**
	Patient signature:	Signature on behalf of patient:

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 & Practice Agreement** (this form!) ☐
2. **Completed & Signed GMS1 Form** ☐
3. **Photo Proof of ID** - e.g. Passport, Photo Driving License or Photo ID card ☐
4. **Proof of Address** – Must be in your name and dated within the past 3 months ☐
   One of the following: Bank statement, Utility Bill (Gas, Electricity, Water), Council Tax or Tenancy Agreement
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 at 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

OFFICE USE ONLY	Need Appt? ☐ Yes ☐ No Need Etoh Advice? ☐ Yes ☐ No			**Staff Initials:**
Photo ID	☐ Passport	☐ Driving licence	☐ Identity card	☐ Other
Proof of Address	☐ Utility Bill	☐ Tenancy Agreement	☐ Bank Statement	☐ Other