Dr. J Greaves
Dr. M Slattery
Dr M Constable
Dr B Whitt

Dr. C Milne
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New Patient Registration Form

Please complete all pages in full using block capitals

1. Background Details

Contact Details			
NHS Number		Date of Birth	
First Name		Known As	
Surname		Previous Surname	
Pronouns		Gender	
Address		Previous Address (if applicable)	
Mobile*		I consent to receiving SMS Messages ☐ Yes ☐ No	
Email*		I consent to receiving emails ☐ Yes ☐ No	
Home Number			
Preferred Contact Method	☐ SMS/Text Message	☐ Email	☐ Letter
Next of Kin	Name:	Tel:	Relationship:
Do you have any family registered here: ☐ Yes ☐ No If yes please supply details below			
Have you been registered with a GP in the NHS before? ☐ Yes ☐ No If no please state date entered UK: _____/_____/_____			

**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. We will never contact you for any other purpose and we will never pass your details onto other organisations.*

Other Details	
Previous GP	Surgery Name: Address:
Country of Birth	
Ethnicity	**White** ☐ English/Welsh/Scottish/Northern Irish/British ☐ Irish ☐ Gypsy or Irish Traveller ☐ Other White Background (please state) **Mixed/Multiple Ethnic Groups** ☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Other Mixed/Multiple Background (please state) **Asian/Asian British** ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Other Asian Background (please state) **Black/African/Caribbean/Black British** ☐ African ☐ Caribbean ☐ Other Black/African/Caribbean Background (please state) **Other Ethnic Group** ☐ Arab ☐ Any Other Ethnic Group (please state)
Religion	☐ C of E ☐ Buddhist ☐ Sikh ☐ No religion ☐ Catholic ☐ Hindu ☐ Jewish ☐ Other: ☐ Other Christian ☐ Muslim ☐ Jehovah's Witness
Sexual Orientation	☐ Heterosexual ☐ Bi-Sexual ☐ Other (please state) ☐ Gay ☐ Prefer not to say ☐ Lesbian ☐ Not Known
Housing	☐ Own House ☐ Nursing Home ☐ Homeless ☐ Asylum Seeker ☐ Rented House ☐ Residential Home ☐ Housebound ☐ Refugee ☐ Shared House ☐ Sheltered Home
Employment	☐ Employed ☐ Student ☐ House husband ☐ Carer ☐ Self-employed ☐ Unemployed ☐ House wife ☐ Retired
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 Do you speak English? ☐ Yes ☐ No
Communication	Do you have any communication needs? ☐ Yes ☐ No (If **Yes** please specify below) ☐ Hearing aid ☐ Large print ☐ British Sign Language ☐ Lip reading ☐ Braille ☐ Makaton Sign Language ☐ Guide dog

Carer Details				
Are you a carer?	☐ Yes – Informal / Unpaid Carer	☐ Yes – Occupational / Paid Carer	☐ No	
Who do you care for?	☐ Parent/Relative	☐ Partner/Spouse	☐ Friend	☐ Child
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*

2. Medical History

Disability

Do you consider yourself to have a disability or long term condition?

☐ Yes ☐ No ☐ Prefer not to say

If you have answered yes, please state the type of impairment that applies to you. You may tick as many boxes as you need. If your condition is not listed, please mark other.

☐ Learning Disability

☐ Mental Health Condition

☐ Physical Impairment

☐ Sensory Impairment

☐ Other (please state)

Medical History

Have you suffered from any of the following conditions?

☐ Asthma	☐ Heart Disease	☐ Diabetes	☐ Depression
☐ COPD	☐ Heart Failure	☐ Kidney Disease	☐ Underactive Thyroid
☐ Epilepsy	☐ High Blood Pressure	☐ Stroke	☐ 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:

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…….	☐ Heart Disease……	☐ Diabetes…….……	☐ Depression……..
☐ COPD……..	☐ Stroke……..	☐ Kidney Disease……	☐ Thyroid…….……..
☐ Epilepsy……	☐ Blood Pressure……	☐ Liver Disease.…..……..	☐ Cancer……..

Other:

Allergies
Please record any allergies or sensitivities below:

Current Medication
Please provide us with a list of your current medication and a copy of your most recent repeat slip:

Women Only	
Do you use any contraception?	☐ Yes ☐ No If needed, please book appointment.
Do you have a coil or implant?	☐ Yes ☐ No Date inserted:
Are you currently pregnant or think you may be?	☐ Yes ☐ No Expected due date:
Date of last Cervical Screen:	

3. Your Lifestyle

Alcohol

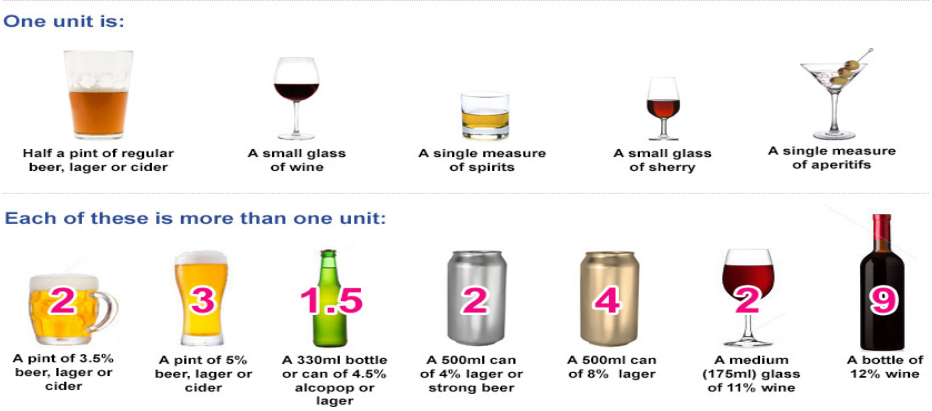
Please answer the following questions which are validated as screening tools for alcohol use:

AUDIT–C 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 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	
					TOTAL:	

A score of **less than 5** indicates *lower risk drinking*

Scores of 5 or more requires the following 7 questions to be completed:

AUDIT QUESTIONS (after completing 3 AUDIT-C questions above)	Scoring System					Your Score
	0	1	2	3	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	
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	
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	
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	
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	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in last year		Yes, during last year	
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 last year		Yes, during last year	
					TOTAL:	



3. Your Lifestyle - Continued

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				

Height & Weight	
Height	
Weight	
BP Reading	_____/_____

*****If you do not know these details, please ask reception for access to our scales and BP machine.

Electronic Prescribing	
Your prescriptions will be sent electronically, please nominate your preferred pharmacy.	Pharmacy:

**If you do not wish to have your prescriptions sent electronically please speak to a receptionist. If a pharmacy is not nominated we will default to Kamsons Beaconsfield Road (next door to the surgery)*

Patient Participation Group	
Would you like to be involved in our Patient Participation Group?	☐ Yes ☐ No

We are committed to improving the services we provide. The Patient Participation Group is a mechanism for us to gain valuable feedback from our patients about their experiences, views and ideas for improving our services.

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	

4. Sharing Your Health Record

What is your health record?

Your health record contains all the clinical information about the care you receive. When you need medical assistance it is essential that clinicians can securely access your health record. This allows them to have the necessary information about your medical background to help them identify the best way to help you. This information may include your medical history, medications and allergies.

Why is sharing important?

Health records about you can be held in various places, including your GP practice and any hospital where you have had treatment. Sharing your health record will ensure you receive the best possible care and treatment wherever you are and whenever you need it. Choosing not to share your health record could have an impact on the future care and treatment you receive. Below are some examples of how sharing your health record can benefit you:

- Sharing your contact details — This will ensure you receive any medical appointments without delay
- Sharing your medical history — This will ensure emergency services accurately assess you if needed
- Sharing your medication list — This will ensure that you receive the most appropriate medication
- Sharing your allergies — This will prevent you being given something to which you are allergic
- Sharing your test results — This will prevent further unnecessary tests being required

Is my health record secure?

Yes. There are safeguards in place to make sure only organisations you have authorised to view your records can do so. You can also request information regarding who has accessed your information from both within and outside of your surgery.

Can I decide who I share my health record with?

Yes. You decide who has access to your health record. For your health record to be shared between organisations that provide care to you, your consent must be gained.

Can I change my mind?

Yes. You can change your mind at any time about sharing your health record, please just let us know.

Can someone else consent on my behalf?

If you do not have capacity to consent and have a Lasting Power of Attorney, they may consent on your behalf. If you do not have a Lasting Power of Attorney, then a decision in best interests can be made by those caring for you.

What about parental responsibility?

If you have parental responsibility and your child is not able to make an informed decision for themselves, then you can make a decision about information sharing on behalf of your child. If your child is competent then this must be their decision.

What is your Summary Care Record?

Your Summary Care Record contains basic information including your contact details, NHS number, medications and allergies. This can be viewed by GP practices, Hospitals and the Emergency Services. If you do not want a Summary Care Record, please ask your GP practice for the appropriate opt out form. With your consent, additional information can be added to create an Enhanced Summary Care Record. This could include your care plans which will help ensure that you receive the appropriate care in the future.

How is my personal information protected?

Preston Park Surgery will always protect your personal information. For further information about this, please see our Privacy Notice on our website or please speak to a member of our team

For further information about your health records, please see: www.nhs.uk/NHSEngland/thenhs/records
For further information about how the NHS uses your data for research & planning and to opt-out, please see: www.nhs.uk/your-nhs-data-matters

4. Sharing Your Health Record (cont)
Do you consent to your GP Practice sharing your health record (please see document attached for more info) 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

Signature	
Signature	☐ Signed on behalf of patient
Name	
Date	

5. Summary Care Record (SCR) Summary Care Record with Additional Information (SCRAI)

If you are registered with a GP practice in England, you will already have a **Summary Care Record (SCR)**, unless you have previously chosen not to have one.
It **only** contains information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

A **Summary Care Record with Additional Information (SCRAI)** contains significantly much more useful information.
It can include information about medication, allergies, adverse reactions, your illnesses and health problems, operations, vaccinations, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

Having a **SCR** or **SCRAI** helps by providing the NHS healthcare staff that are treating you with vital information from your health record. This will help the staff (especially if they do not know you) make better and safer decisions about how best to treat you.

You have the choice of what information you would like to share and with whom. Please note only authorised NHS healthcare staff can only view your **SCR** or **SCRAI** with your permission and using an auditable means of access. The information shared will solely be used for the benefit of your care and remains confidential.

At Preston Park Surgery we strongly encourage you to consider opting to have a **Summary Care Record with Additional Information (SCRAI)**, as it contains so much more information and is therefore significantly more useful both to you and the NHS staff treating you.

You have a choice

Having read the above information regarding your choices, please choose **one** of the options below

Your Health Record
Do you consent to your GP Practice sharing your health record (please see document attached for more info) with other organisations who care for you? ☐ Express consent for medication and allergies, adverse reactions and additional information (SCRAI) ☐ Express consent for medication and allergies, adverse reactions (SCR) ☐ I would not like a Summary Care Record

Signature	
Signature	☐ Signed on behalf of patient
Name	
Date	

6. Application for online access to my medical record (over 16's only)

A higher standard of documentation is needed for online registration. You will need two forms of documentation, one of which must contain a photo. Acceptable documents include passports, photo driving licences and bank statements (see attached list). Online login details will be emailed/texted to you (providing you have consented) only after you have responded to an automated verification message.

Full Name			
Date of birth		Email Address	
Address			

I wish to have access to the following online services (please tick all that apply)	
Booking Appointments	☐
Requesting repeat prescriptions	☐
Requesting my Summary Care Record (SCR)	☐
Accessing my Detailed Coded Record*	☐

***Please note:** There is a waiting list for this functionality due to the high workload required in checking and enabling coded record access. Access cannot be granted until your medical record has been received from your previously surgery and summarised, which currently takes approximately 8 weeks. Full records access it not available at this surgery.

I wish to access my medical record online and understand and agree with each statement (tick)

I wish to access my medical record online and understand and agree with each statement (tick)	
I have read and understood the information leaflet provided by the practice	☐
I will be responsible for the security of the information 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 is not about me or is inaccurate, I will contact the practice as soon as possible.	☐

Signature	
Signature	☐ Signed on behalf of patient
Name	
Date	

Practice Use Only

Appointment	☐ Required	☐ Not Required		
Photo ID	☐ Passport	☐ Driving licence	☐ Identity card	☐ Other
Proof of Address	☐ Utility Bill	☐ Council Tax	☐ Bank Statement	☐ Other