**New Patient Registration**

**Additional Contact Information**

Mobile or Work Telephone Number:…………………………………………

Email Address: ………………………………………………………………….

**Do you look after a relative or friend, young or old, who is unable to care for themselves due to a physical or mental impairment or by age?** **YES / NO**

If so, we would like to support you and ask that you please complete the following:

Name of the person you are Caring for: ……………………………………..

their address ………………………………………………………….

………………………………………………………….

their telephone No ………………………………………………………….

In order that we may take into account a patient’s culture, religion and background when providing appropriate individual care, your assistance in completing this section is greatly appreciated as it helps us to improve our policies and practices

White British Pakistani

White Irish Bangladeshi

White Other Other Asian background

White & Black Caribbean Black Caribbean

White & Black African Black African

White & Asian Other Black background

Other Mixed background Chinese

Indian Any Other

**Additional Information**

Height: Weight:

As a practice we offer new patient appointments, would you like to book one: Yes/No

Are you taking any regular medication?Please list;(use additional sheet if req’d)

**Summary Care Record** (Please refer to additional information sheets)

 **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you.

 **Undecided -** enclosed is an opt out form. Please complete the form and hand it to a member of the GP practice staff within 12 weeks. If you do nothing, after this time, we will assume that you are happy with these changes and create a Summary Care Record for you.

 **No I do not want a Summary Care Record –** enclosed is an opt out form. Please complete the form and hand it to a member of the GP practice staff.

# Smoking status- Over 16 yrs

Current Smoker 

Current Non-Smoker  → Date/Year Stopped Smoking ……………

Never Smoked Tobacco 

**Assistance During Appointments**

In order for us to provide you with any assistance you may require during consultations, please let us know if you would benefit from any of the following:-

First language **NOT** English – require a translator 

Deafness – require a sign language translator 

Disability – require a carer 

# Female Patients only

In order that we can arrange the correct follow-up, please let us know if you are using either of the following contraceptive devices:-

IUCD (coil)  Date of insertion……………………………….

Implanon/Nexplanon  Date of insertion……………………………….





**IDENTIFICATION DOCUMENTS REQUIRED WHEN REGISTERINGAS A NEW PATIENT**

When returning the completed registration form, please bring your proof of identification. If available

**PROOF OF NAME**

**(One of the following)**

Birth Certificate

Marriage Certificate

Driving Licence (valid)\*

Passport (Valid)\*

**PROOF OF ADDRESS;MUST BE DATED WITHIN THE LAST 3 MONTHS**

**(One of the following)**

Utility Bill

Council Rent Book

Bank Statement

Credit Card Statement

Letter from Benefits Agency

**\*Please note if applying for Online Access to your medical records, photo ID must be produced.**

**Information for our patients.**

**We're improving how we communicate with patients.**

**Please tell us if you need information in a different format or need communication support.**



**Out of area registration:**

New arrangements introduced from January 2015 give people greater choice when choosing a GP practice. Patients may approach any GP practice, even if they live outside the practice area, to see if they will be accepted on to the patient list.

GP practices have always had the ability to accept patients who live outside their practice area. Regardless of distance from the practice, the practice would still provide a home visit if clinically necessary.

The new arrangements mean GP practices now have the option to register patients who live outside the practice area **but without any obligation to provide home visits.**

Out of area registration (with or without home visits) is voluntary for GP practices meaning patients may be refused because they live out of area.

If your application is considered the GP practice will only register you without home visits **if it is clinically appropriate and practical in your individual case**. To do this we may:

- Ask you or the practice you are currently registered with questions about your health to help decide whether to register you in this way

- Ask you questions about why it is practical for you to attend this practice (for example, how many days during the week you would normally be able to attend)

If accepted, you will attend the practice and receive the full range of services provided as normal at the surgery. If you have an urgent care need and the surgery cannot help you at home we may ask you to call NHS 111 and they will put you in touch with a local service (this may be a face to face appointment with a local healthcare professional or a home visit where necessary).

We may decide that it is not in your best interests or practical for you to be registered in this way. In these circumstances we may offer you registration with home visits, for example:- if you live just outside the practice area or we may not register you and advise you should seek to register (or remain registered) with a more local practice.

If accepted, but your health needs change, we may review your registration to see if it would be more appropriate for you to be registered with a GP practice closer to your home.

This new arrangement only applies to GP practices and patients who live in England. For further information visit the NHS Choices website (www.nhs.uk)

**Application for online access to my medical record**

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Telephone number | Mobile number |

I wish to have access to the following online services (please tick all that apply):

|  |  |
| --- | --- |
| 1. Booking appointments |  |
| 1. Requesting repeat prescriptions |  |
| 1. Accessing my medical record |  |

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

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice |  |
| 1. I will be responsible for the security of the information that I see or download |  |
| 1. If I choose to share my information with anyone else, this is at my own risk |  |
| 1. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible |  |
| 1. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |  |
| 1. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible. |  |

|  |  |
| --- | --- |
| Signature | Date |

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient NHS number | | Practice computer ID number | |
| Identity verified by  (initials) | Date | Method  Vouching  Vouching with information in record  Photo ID and proof of residence | |
| Authorised by | | Date | |
| Date account created | | | |
| Date passphrase sent | | | |
| Level of record access enabled  All  Prospective  Retrospective  Detailed coded record  Limited parts | | | Notes / explanation |

**FOR PRACTICE USE ONLY**

|  |  |
| --- | --- |
|  | Checked By (Initials) |
| Registration Form completed and signed |  |
| Ethnicity completed |  |
| Alcohol Screening Questions completed |  |
| Smoking Status completed |  |
| SCR option selected (Opt-Out Form completed if dissent given) |  |
| ID Verified and photocopied |  |
| New Patient Screening appt made |  |
| Given Named GP letter |  |
| Check if requesting online access and if so sign to say you have seen ID |  |