Emis No:

Vale Medical Group

PATIENT REGISTRATION FORM

Please tick at which Surgery the patient will be registered

☐ Long Clawson Medical Practice ☐ Stackyard Surgery ☐ Woolsthorpe Surgery

Thank you for applying to join Vale Medical Group. We would like to gather some information about you and ask that you fill in the following questionnaire. You don't have to supply answers to all of the questions but what you do fill in will help us give you the best possible care.

Please supply two forms of Identification with your completed form, a photographic form of ID (such as passport or driving license) and proof of your home address (such as a recent bank statement or document relating to your new home).

Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes. Fields marked with an asterix (*) are mandatory.

*Title *Surname	*First names
*Any previous surname(s)	*Date of Birth
* ☐ Male ☐ Female	NHS No. ☐☐☐☐☐☐☐☐☐☐
Town and country of birth	*Home address
*Home telephone No.	
Work telephone No.	*Postcode
*Mobile No. (if you have one)	Email address

Previous address and doctors details

*Previous address in the UK Postcode	Name of previous doctor while at that address Address of previous doctor

If you are from abroad

*Your first UK address where you registered with a GP if you were previously living abroad Postcode	*If previously a resident in the UK, date of leaving *Date you first came to live in the UK if applicable

Armed Forces

Have you ever been in the employ of the Armed Forces? ☐ Yes (tick below which apply) ☐ No

☐ Army (Code 13Ji0)	☐ RAF (Code 13Ji1)	☐ Navy (Code 13Ji2)

Address before enlisting Postcode	Service or Personnel No. Enlistment date Leaving date

Additional details about you

What is your ethnic group?

White	☐ British	☐ Irish			
Black	☐ Caribbean	☐ African			
Asian	☐ Indian	☐ Pakistani	☐ Chinese		
Mixed	☐ White + Black Caribbean	☐ White + African	☐ White + Asian		
Other	☐ *Please specify*:				

Height	ft	in
Weight	st	lb
Waist measurement	in	

(**for women only**) Have you had a cervical smear?
☐Yes ☐No (*Please state where, when and the result if possible*)

*Do you consent to the shared NHS Summary Care Record (SCR)?
☐Yes ☐No
More details concerning the Summary Care Record and what it means to you can be found by visiting:
www.nhscarerecords.nhs.uk

*Do you consent to receive emails, text messages and answering machine messages from the Surgery?

Emails	☐Yes (Code 9Nds)	☐No
Mobile Phone Text Messages	☐Yes (Code 9Ndp)	☐No
Answering Machine Message	☐Yes (Code 9Ndi)	☐No

Health & Social Care Information Centre (HSCIC)
Whilst the SCR mentioned above shares a very small portion of your medical record across the whole NHS, the HSCIC shares a much fuller view of your records but only with NHS providers – and only when you give explicit consent at the point of care.

Tick this box if you wish to <u>opt out</u> of the HSCIC ☐

Do you have a Carer?	☐Yes (Code 918F) ☐No
If yes, what is their name and contact number?	……
Do you consent for your carer to be informed about your medical care?	☐Yes ☐No
Are you a Carer?	☐Yes (Code 918G) ☐No
If yes, do you look after someone who is a patient of the Surgery?	☐Yes ☐No ☐ Don't know
Are they?	☐Relative ☐Friend ☐Neighbour

Next of kin

Name of next of kin	Relationship to you
Next of kin telephone number(s)	Next of kin address (if different to above)

If the patient is under 18 years old, who has parental responsibility?

I wish to have access to the following online services (tick all that apply):
(Please note that under 16's will not have access)

Booking appointments	
Requesting repeat prescriptions	
Accessing my medical record (medication, allergies, immunisation)	

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

I will be responsible for the security of the information that 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 log out immediately and contact the Practice as soon as possible	

Medical details

In order to continue to receive your repeat medications you'll need to make an appointment with a GP at least one week before your next prescription is due.

*Are you allergic to any medicines? ☐ Yes ☐ No (if yes please specify)

*List other allergies (pollen, animal hair or certain foods. Please mark "none" if you have no other allergies that you know of)

Have you ever had any of the following conditions?

Epilepsy	☐ Yes	Year	**Mental Illness**	☐ Yes	Year
High Blood Pressure	☐ Yes	Year	**Diabetes**	☐ Yes	Year
Heart Attack / Angina	☐ Yes	Year	**Asthma**	☐ Yes	Year
Stroke / Mini-stroke (TIA)	☐ Yes	Year	**COPD (or Emphysema)**	☐ Yes	Year
Cancer	☐ Yes	Year	**Osteoporosis / Bone fractures**	☐ Yes	Year
Rheumatoid Arthritis	☐ Yes	Year	**Peripheral vascular disease**	☐ Yes	Year

List any serious illnesses / operations / accidents / disabilities (women: any pregnancy related problems) & the year they took place

Do you have family history of any of the following?

High Blood Pressure	☐ Yes	Who	**DVT / Pulmonary Embolism**	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged >60 yrs	☐ Yes	Who	**Breast Cancer**	☐ Yes	Who
Ischaemic Heart Disease Diagnosed aged <60 yrs	☐ Yes	Who	**Any Cancer** Specify type:	☐ Yes	Who
Raised Cholesterol	☐ Yes	Who	**Thyroid disorder**	☐ Yes	Who
Stroke / CVA	☐ Yes	Who	**Epilepsy**	☐ Yes	Who
Asthma	☐ Yes	Who	**Osteoporosis**	☐ Yes	Who

Please tell us about your smoking habits

Do you smoke? ☐ Yes ☐ No

If Yes, what do you primarily smoke:
Cigarettes / Cigar / Pipe (please circle)

How many do you smoke a day?
Would you like advice on quitting? ☐ Yes ☐ No

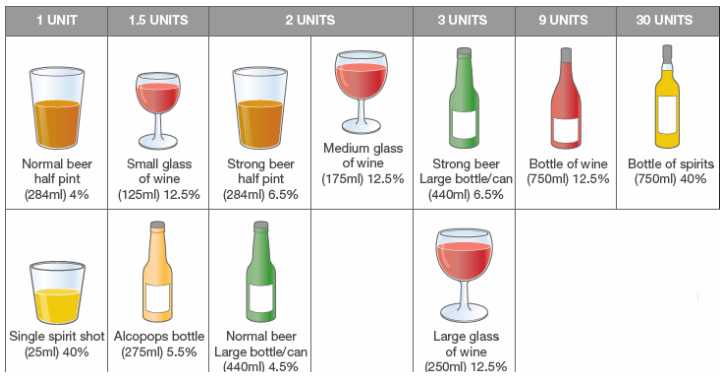
Are you an ex-smoker ☐ Yes ☐ No
When did you quit?

How many did you used to smoke a day?

Please tell us about your alcohol consumption

Questions (please circle your answers)	**Unit scoring system**				
	0	**1**	**2**	**3**	**4**
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times Per month	2 - 4 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

Depending on your answers above you may be asked to complete an additional alcohol questionnaire.



Please record any additional information about you that you think is important for us to know

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

For more information, please visit the website *www.uktransplant.org.uk* or call 0300 123 23 23

***Signed**

***Date / / /**

Signed on behalf of patient (*if applicable*)
(e.g. for minors under 16 years old, adults lacking capacity)

You will be eligible for a New Patient Health Check with a Practice Nurse or Health Care Assistant. Please contact Reception for an appointment.

FOR OFFICE USE ONLY

PHOTO ID ☐ **TYPE: PASSPORT DRIVING LICENCE MILITARY ID**
(Over 18 only)

ADDRESS ID ☐ **TYPE: _____**

☐ **ID/Address (Code 91B)**

NAMED ACOUNTABLE GP
Place the following code on patient record

Patient Allocated Named Accountable General Practitioner – 9NN60

Allocated to: ……

Informing Patient of Named Accountable General Practitioner – 67DJ

Allocated to: ……