



Readesmoor Medical Centre New Patient Registration Form

If you would like this letter or information in an alternative format, for example large print or easy read, or if you need help with communicating with us, for examples because you use British Sign Language, please let us know.

You can call us on (01260) 276161

Please complete in **BLOCK CAPITALS** and tick the boxes as appropriate.
Please complete a separate form for each family member to be registered.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Full Name:	Date of Birth	NHS Number (if known)
(Please circle) Mr / Mrs / Miss / Ms / Other.....		
Previous/ Mother's surname if different:		
Marital Status	Gender: Male <input type="radio"/> Female <input type="radio"/>	
Address and postcode:		
Housing (Please circle one): House/ Maisonette / Flat/ Mobile Home/ Other		
Other residents of your home:		
Telephone Number:	Mobile Number:	
Work Number:	E-mail Address:	
Town & Country of Birth		
Next of Kin & relationship to you:	Next of Kin Contact number:	
Do you have a social worker? If yes, please supply their name and contact details. Yes <input type="radio"/> No <input type="radio"/>		
Occupation:	Names and ages of Children	
Height: Feet/inches: cm:	Weight: Stones/lbs: kg:	

Previous Address and Postcode:						
Previous Doctor Name and Address:				Previous Doctor Tel. No.		
Previous Data released? Yes <input type="radio"/> No <input type="radio"/>						
If applicable, date you first came to live in Britain						
If returning from the Armed Forces		Your Service or Personnel Number:		Your Enlistment Date:		
				Your Release Date:		
Your Religion (please circle one):						
C of E	Catholic	Other Christian (state)	Buddhist	Hindu	Muslim	
Sikh	Jewish	Jehovah's Witness	No religion	Other religion (state)		
Your Ethnic Origin (please circle):						
White (UK) 9i0	White (Irish) 9i1%	White (Other) 9i2%	Caribbean 9i3			
African 9i4	Asian 9i5	Other Mixed Background 9i6%	Indian / Brit Indian 9i7			
Pakistani / Brit Pakistani 9i8	Bangladeshi / Brit Bangladeshi 9i9	Other Asian Background 9iA%	Other Black Background			
Chinese 9iE	Other 9iF%	Ethnic Category not stated 9iG				
Your main or 1 st language Spoken/Understood (please circle one):						
English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi	
Polish	Ukrainian	French	German	Spanish	Other:(Please Specify)	
Smoking, Alcohol Consumption and Exercise:						
Are you currently a smoker? Yes <input type="radio"/> No <input type="radio"/>			Have you been a smoker? Yes <input type="radio"/> No <input type="radio"/>			
If you are a current smoker, how many cigarettes/ cigars/ tobacco do you smoke in a day?...						
<i>If you are a smoker and want to stop, please ask for information about local smoking cessation services.</i>						
How much alcohol do you drink in a week (Units)? <i>(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)</i>						
	0	1	2	3	4	Your score
How often do you have a drink that contains alcohol?	Never	Monthly	2-4 times per month	2-3 times per week	4+ times per week	

Partners:Drs E A Carter S A Thomas S Percy J S Barnsley V L Buckley
Associate GPs: Dr H Worthington V Kaushik

How many Standard alcoholic drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

How often do you exercise? No. times per week:	Type(s) of exercise:
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Your Medical Background:				
What illnesses have you had & When?				
What operations have you had and When?				
Do you have any medical problems at present?				
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)				
Are you able to administer your own medicines? (please circle)		Yes	No – please detail specific issues (e.g. swallowing, opening containers)	
Are there any serious diseases that affect your Parents, Brothers or Sisters (please circle)				
Diabetes	Heart Attack	Heart attack under age of 60	Bowel Cancer	Breast Cancer
High Blood Pressure	Asthma	Stroke	Thyroid Disorder	Any other important Family Illness?
What immunisations have you had? (please circle all that apply)				
Diphtheria	Measles	German Measles	Tetanus	Polio
				MMR
Whooping Cough		Pre-school booster		Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses
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 have (i.e. Speech, Hearing, Sight):				

Are you an 'Assistance Dog' User?		
Please state any Physical disabilities you have:		
Please state any Mental disabilities you 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:		
Please state any allergies and sensitivities you have:		
Please state any phobias you have:		
If you are a Carer, please state the name / address / phone number of the person you care for: PLEASE SPEAK WITH RECEPTION TO DISCUSS GAINING CONSENT TO ACCESS MEDICAL RECORDS FOR THE PERSON YOU CARE FOR IF APPROPRIATE	<u>Person Cared For Contact Details:</u>	
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.	<u>Carer Contact Details:</u>	
	<u>Signed:</u> <u>Date:</u>	
Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	Yes / No	<i>If "Yes", can you please bring a written copy of it to your New Patient Consultation</i>
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 / phone number:
Women only:		
When was your last smear done?	Date: Yes No	Was this at your GP's Surgery? <input type="radio"/> <input type="radio"/>
What was the result of the smear?		

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Date of last mammogram (if applicable):	Date:	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 <input type="radio"/> <input type="radio"/>			
<p><u>Summary Care Records.</u></p> <p>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. An information pack has been provided.</p> <p><u>National Data Programme (Care Data)</u></p> <p>Please read the leaflet attached to the registration form. You can set your opt-out choice at nhs.uk/your-nhs-data-matters</p>			
Are you happy to have a Summary Care Record?	Yes <input type="radio"/>	No	More Time Required to decide:
<p><u>Patient Participation Group</u></p> <p>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. We have a patient Participation group who meet with us to discuss such issues. If you are interested in getting involved, please leave your details with Reception for the attention of Mrs Roz Broad.</p>			

Do you have a long term health condition?

If you have a long term health condition such as Diabetes, COPD (chronic obstructive lung disease). Please book an appointment via reception to see the nurse covering that illness. 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.*

Are taking any regular medication?

If you are taking regular medication and do not need an appointment with the practice nurse, Please book a telephone appointment to speak to a GP to ensure that this can be continued and reviewed

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or see our website: www.readesmoor.co.uk

Patient signature:

Date: