



# New Patient Registration Form Adult

Please complete all pages in full using block capitals

## 1. Background Details

Contact Details			
NHS Number			
Name		Gender	
Previous Surname (if applicable)			
Address		Date of Birth	
		Home Telephone	
		Work Telephone	
Mobile Telephone	I consent to be contacted* by SMS on this number:		
Email	I consent to be contacted* by email at this address:		
Next of Kin	Name:	Tel:	Relationship:
In Emergency Contact (ICE)	Name:	Tel:	Relationship:
Has the patient been registered in the NHS before? <input type="checkbox"/> Yes <input type="checkbox"/> 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**

**If you do NOT consent to being contacted by SMS or Email, please tick here:**

SMS  Email

Communication Needs	
Language	What is your main spoken language? Do you need an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No
Communication	Do you have any communication needs? <input type="checkbox"/> Yes <input type="checkbox"/> No (If <b>Yes</b> please specify below) <input type="checkbox"/> Hearing aid <input type="checkbox"/> Large print <input type="checkbox"/> British Sign Language <input type="checkbox"/> Lip reading <input type="checkbox"/> Braille <input type="checkbox"/> Makaton Sign Language <input type="checkbox"/> Guide dog

**Are you a carer?**  Yes  No

**If yes, please ask the Receptionist for a Carer's questionnaire and leaflet**

## 2. Medical History

### Medical History

Do you suffer from any of the following conditions?

<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Depression
<input type="checkbox"/> COPD	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Underactive Thyroid
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Cancer- Type:

Any other conditions?

### 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

<input type="checkbox"/> Asthma.....	<input type="checkbox"/> Heart Disease.....	<input type="checkbox"/> Diabetes.....	<input type="checkbox"/> Depression.....
<input type="checkbox"/> COPD.....	<input type="checkbox"/> Stroke.....	<input type="checkbox"/> Kidney Disease.....	<input type="checkbox"/> Thyroid.....
<input type="checkbox"/> Epilepsy.....	<input type="checkbox"/> Blood Pressure.....	<input type="checkbox"/> Liver Disease.....	<input type="checkbox"/> Cancer.....

Other:

### Allergies

Please record any allergies or sensitivities below

### Current Medication

Please check and include as much information about your current medication below  
Please give us your previous repeat medication list if possible and a medication review appointment may be needed

### 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:						

#### One unit is:



Half a pint of regular beer, lager or cider



A small glass of wine



A single measure of spirits



A small glass of sherry



A single measure of aperitifs

#### Each of these is more than one unit:



A pint of 3.5% beer, lager or cider



A pint of 5% beer, lager or cider



A 330ml bottle or can of 4.5% alcopop or lager



A 500ml can of 4% lager or strong beer



A 500ml can of 8% lager



A medium (175ml) glass of 11% wine



A bottle of 12% wine

### 3. Your Lifestyle - Continued

Smoking			
Do you smoke?	<input type="checkbox"/> Never smoked	<input type="checkbox"/> Ex-smoker	<input type="checkbox"/> Yes
Do you use an e-Cigarette?	<input type="checkbox"/> No	<input type="checkbox"/> Ex-User	<input type="checkbox"/> Yes
How many cigarettes did/do you smoke a day?	<input type="checkbox"/> Less than one	<input type="checkbox"/> 1-9	<input type="checkbox"/> 10-19 <input type="checkbox"/> 20-39 <input type="checkbox"/> 40+
Would you like help to quit smoking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	For further information, please see: <a href="http://www.nhs.uk/smokefree">www.nhs.uk/smokefree</a> or book a <b>STOP SMOKING</b> appointment at Reception

Height & Weight	
Height	
Weight	
Waist Circumference	
Please use the machine in Reception for the following:	
BP	
Pulse	

Women Only	
Are you currently pregnant or think you may be?	<input type="checkbox"/> Yes <input type="checkbox"/> No Expected due date:

Students Only			
Students are at risk of certain infections including mumps, meningitis and sexually transmitted infections, as well as mental health issues including stress, anxiety and depression. Please see <a href="http://www.nhs.uk/Livewell/Studenthealth">www.nhs.uk/Livewell/Studenthealth</a>			
I am less than 24 years old and have had two doses of the MMR Vaccination	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
I am less than 25 years old and have had a Meningitis ACWY Vaccination	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure

## 4. Further Details

### Electronic Prescribing

If you would like your prescriptions to be sent electronically, please provide details of the pharmacy you would like to use:

### 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.*

### Blood and Organ Donation

#### Blood Donation

- I am already a blood donor  
 I wish to be a blood donor  
 I do not wish to be a blood donor

To register: Online: [www.blood.co.uk/the-donation-process/recognising-donors](http://www.blood.co.uk/the-donation-process/recognising-donors)  
Telephone: 0300 123 23 23 to speak to an advisor who will send out a donor card.

#### Organ Donation

- I am already registered as a donor  
 I wish to be a donor – all body parts  
 I wish to be a donor – for these body parts:  
 kidneys  heart  liver  corneas  lung  pancreas  
 I do not wish to be a donor

To register: Online: [www.organdonation.nhs.uk](http://www.organdonation.nhs.uk)  
Telephone: 0300 123 23 23 to speak to an advisor who will send out a donor card.

### 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

## 5. Sharing Your Health Record

### Your Summary Care Record (SCR)

When you register with a GP practice in England your SCR is created automatically, unless you have opted out. Your Summary Care Record is a short summary of your GP medical records. It tells other health and care staff who care for you about the medicines you take and your allergies.

With your consent, additional information can be added to create an Enhanced Summary Care Record  
Do you consent to having an Enhanced Summary Care Record?

- Yes (*recommended option*)  
 No

If you wish to opt out of having a Summary Care Record, please ask Reception for an Opt Out form

### Other Details

Previous GP	Name:	Address:		
Country of Birth				
Ethnicity	<input type="checkbox"/> White (UK)	<input type="checkbox"/> Black Caribbean	<input type="checkbox"/> Bangladeshi	<input type="checkbox"/> Chinese
	<input type="checkbox"/> White (Irish)	<input type="checkbox"/> Black African	<input type="checkbox"/> Indian	<input type="checkbox"/> Other
	<input type="checkbox"/> White (Other)	<input type="checkbox"/> Black Other	<input type="checkbox"/> Pakistani	
Armed Forces	<input type="checkbox"/> Military Veteran	<input type="checkbox"/> Family member		

### Checklist

Please ensure the following are done and provided so that your registration can be completed successfully

- Completed & Signed Above Form  
 Completed & Signed GMS1 Form  
 Photo Proof of ID *e.g. Passport, Photo Driving License or Photo ID card*  
 Proof of Address *e.g. Bank statement, Utility Bill or Council Tax from within the last 3 months*

### Practice Use Only

Appointment	<input type="checkbox"/> Required	<input type="checkbox"/> Not Required		
Photo ID	<input type="checkbox"/> Passport	<input type="checkbox"/> Driving licence	<input type="checkbox"/> Identity card	<input type="checkbox"/> Other
Proof of Address	<input type="checkbox"/> Utility Bill	<input type="checkbox"/> Council Tax	<input type="checkbox"/> Bank Statement	<input type="checkbox"/> Other
Checked by:				
Date:				

# 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?

Spa Medical Centre 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](http://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](http://www.nhs.uk/your-nhs-data-matters)





## 6. Online Access To Your Health Record

Name  
 NHS Number  
 Date of Birth  
 Address  
 Telephone  
 Email Address

### I wish to have online access to: *Please tick all that apply*

- View & book appointments  
 View & request medication  
 Access my coded medical record (*contains any medical codes that have been recorded*)  
**PLEASE ALLOW 20 WORKING DAYS FOR THIS ACCESS TO BE PROCESSED**  
 Access my Summary Care Record  
 Complete online questionnaires

### I wish to access my medical record & understand & agree with each statement: *Please tick all that apply*

- I have read and understood the 'Important Information' section below  
 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 it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible

Please bring photographic proof of your identification in order for the sign up process to be completed

Signature	
Signature	
Name	
Date	

Patient NHS number			
Identity verified by (initials)	Date	Method	Vouching <input type="checkbox"/> Vouching with information in record <input type="checkbox"/> Photo ID and proof of residence <input type="checkbox"/>
Date account and passphrase created			
Authorising GP:			Date
GP signature:			
Level of record access enabled Contractual minimum <input type="checkbox"/> (DCRA)	Notes / explanation		

# Access to GP Online Services

## Important Information – Please read before completing form below

If you wish to, you can now use the internet (via computer or mobile app) to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well. It's your choice.

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. If you are unable to do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.

During the working day it is sometimes necessary for practice staff to input into your record, for example, to attach a document that has been received, or update your information. Therefore you will notice admin/reception staff names alongside some of your medical information – this is quite normal.

The definition of a full medical record is all the information that is held in a patient's record; this includes letters, documents, and any free text which has been added by practice staff, usually the GP. The coded record is all the information that is in the record in coded form, such as diagnoses, signs and symptoms (such as coughing, headache etc.) but excludes letters, documents and free text.

Before you apply for online access to your record, there are some other things to consider. Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.

### **Forgotten history**

There may be something you have forgotten about in your record that you might find upsetting.

### **Abnormal results or bad news**

If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.

### **Choosing to share your information with someone**

It's up to you whether or not you share your information with others – perhaps family members or carers. It's your choice, but also your responsibility to keep the information safe and secure.

### **Coercion**

If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time.

### **Misunderstood information**

Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.

### **Information about someone else**

If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible.

For further information, please see:

[www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/gp-online-services.aspx](http://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/gp-online-services.aspx)