Clarendon Lodge Medical Practice

New Patient Registration Forms

New Patient Registration Checklist for Reception

Paperwork given and explained	Date when given out and initials of Receptionist	Please ensure that patients retain the pack and Practice Leaflet as this contains essential information.	
Information pack / essential information for registration			
Practice Leaflet			
PPN			
		Date when received back and initials of Receptionist	If not completed – why
GMS 1 form			
New Patient Questionnaire			
Explicit Consent form			
Summary Care Record form			
Online Access form			
Electronic Prescription form			
New Patient Consultation	Please ensure that you offer and book in a New Patient Consultation or NHS Health Check as appropriate – Date booked: ……		

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IDENTIFICATION CHECK

Identity verified by (initials) **RECEP TO CHECK:-**	**Date**	**<u>Photo ID</u>** **Driving Licence ☐** **Passport ☐** **ID Card ☐** **<u>Proof of Residence</u>** **Tenancy Agreement ☐** **Utility Bill ☐** **Council Tax ☐** ***<u>RECEP PLEASE TICK ONE OF EACH</u>***

Welcome to Clarendon Lodge Medical Practice. We would be grateful if a confidential questionnaire could be completed for every new patient registering with the practice. Once the completed questionnaire is returned, together with the attached 'family doctor services registration form', we will be able to proceed with your registration.

We offer all patients, registering with the Practice, a **"new patient consultation".** We strongly recommend that you make an appointment because the information gained at this meeting and through the questionnaire, helps us to provide you with the best care and attention possible.

Thank you for your time.

Surname	**First Name/s**
Title	**Known as**
Date of birth	**Occupation**
Next of Kin (NOK)……	**Contact tel.no. for NOK……**
Do you have a Carer? YES / NO If yes – please give name and contact telephone number …… **Are you a Carer? YES / NO If yes – please give name, relationship to you (with permission) (not as your employment) and contact number……** **……** **Is this person a patient at the Practice? YES / NO** **Are you happy for our Care Administrator to contact you? YES/ NO**	

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PERSONAL MEDICAL HISTORY

1.	**Significant Illnesses/Conditions** (please tick relevant boxes)				
Insulin treated diabetes	☐	Tablet treated diabetes	☐	Diet controlled diabetes	☐
High blood pressure	☐	Heart disease	☐	Asthma	☐
Cancer	☐	Epilepsy	☐	Thyroid problems	☐
Stroke	☐	Other chest problems	☐	Other ……..	

2.	**Operation/s**	**Date/s**

3.	**Other Admission/s to hospital**	**Date/s**

FAMILY MEDICAL HISTORY
(please tick relevant boxes)

High Cholesterol of 7.5 or greater ☐			If so, which member of the family?		
Heart Attack ☐	If so, which member of your family? How old were they when they had the heart attack?				
Heart disease ☐	Stroke ☐	Cancer ☐	Diabetes ☐	Hypertension ☐	Asthma ☐
Other ☐ (please specify)					

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DRUGS AND MEDICINES

(please tick relevant boxes)

Are you being prescribed medication on a repeat basis	☐ yes ☐ no
Are you allergic to any medications? ☐ yes ☐ no If yes, please state …….. ……	

DISABILITY INFORMATION

(please tick relevant boxes)

Partially sighted	☐	Blind ☐	Hearing impaired ☐	Deaf ☐	Speech Defect ☐
Dyslexia ☐		Learning disability ☐	Mental Illness ☐	Mobility problem (please explain) ☐	

LIFESTYLE

(please tick relevant boxes)

Do you smoke?	yes☐ no ☐	If yes, number per day ……..
If 'no' are you an ex-smoker?		yes ☐ no ☐

How often do you have a drink that contains 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 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/almost daily☐
Scoring System	0	1	2	3	4
A total of 5+ indicates increasing or higher risk drinking. If you score 5+ we recommend that you make an appointment with one of our nursing team.					**Overall score =**

Exercise	Very active ☐	Moderate ☐	Gentle ☐	Inactive ☐

Diet	Good ☐	Moderate ☐	Poor ☐	Vegetarian ☐	Vegan ☐

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ABOUT YOU
(please tick relevant boxes)

Height ……..	Weight ……..

Non-drug allergies (ie nuts, insect bites, pollen) ……..			
Mild ☐	Moderate ☐	Severe ☐	Very Severe ☐

Do you take Aspirin regularly, which you buy over the counter? Yes ☐ No ☐

Have you had any of the following immunizations? Please give the date (year will suffice) and stage ie booster etc.

Tetanus ☐	date ……	stage ……..
Combined Diphtheria/Tetanus ☐	date ……	stage ……..
Polio	date ……	stage ……..
Flu ☐ date …….	Pneumovax ☐	date …….

FOR WOMEN

Form of contraception used:

The Pill ☐	Coil (IUD) ☐	Condom ☐	Diaphragm (Cap) ☐

Ethnicity

White					
British		Irish		Other	
Mixed					
White/Black Caribbean		White/Black African		Other mixed background	
White/Asian					
Asian					
Indian		Pakistani		Other Asian background	

Bangladeshi					
Black or Black British					
Caribbean		African		Other	
Chinese					
Other					
Other		Unknown			

Religious Beliefs

Baha'i		Buddhist		Sikh	
Christian		Hindu		Zoroastrian	
Jain		Jewish		Unknown	
Muslim		None		Other	
Pagan					

Sexual Identity

Heterosexual/Straight		Gay or Lesbian	
Bisexual		Other	
Unknown			

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PLEASE ENSURE THAT YOU HAVE READ THE INFORMATION ENCLOSED IN THE REGISTRATION PACK WITH REGARDS TO YOUR CONSENT.

CONSENT TO COMMUNICATING WITH YOU

To ensure that we comply with the new General Data Protection Regulations we need to ensure that you consent to the way we contact you and would appreciate it if you could complete the following questions:

Patient's Last name …….. First Name: ……

Date of Birth : …… Mobile Number: ……..

Email Address: ……..

Please tick an answer to each question below:

MOBILE TELEPHONE COMMUNICATION

We will use the mobile number supplied by you for this communication, so please consider if this is shared with others.

It is your responsibility to advise us of changes to your mobile phone number.

I consent to Clarendon Lodge Medical Practice contacting me via SMS (text) messaging to remind me of booked appointments and to advise me regarding services offered relating to my healthcare.

☐ YES ☐ NO (i.e.decline)

EMAIL COMMUNICATION

We will use the email address supplied by you for this communication, so please consider if this is shared with others.

It is your responsibility to advise us of changes to your email address.

I consent to Clarendon Lodge Medical Practice contacting me via email messaging to advise me regarding services offered relating to my healthcare.

☐ YES ☐ NO (i.e.decline)

SUMMARY CARE RECORD (SCR)

PLEASE ENSURE THAT YOU HAVE READ THE INFORMATION ENCLOSED IN THE REGISTRATION PACK WITH REGARDS TO YOUR SUMMARY CARE RECORD

You do not have to have a Summary Care Record, although you are strongly recommended to consider this choice.

☐ I agree to my Summary Record to contain once core information (see attached sheet)
☐ I agree to my Summary Care Record to contain Additional Information (see attached sheet)
☐ I decline to my Summary Care Record

If you decided to proceed, but at any time in the future you choose not to have a Summary Care Record, all you need do is write to your Surgery informing them of your decision to "Opt-out". If you have already told your Surgery that you wish to "Opt-out" and you wish this to remain in place you need take no further action.

Signed by Patient …….. Date ……..

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Application for online access to my medical record

PLEASE ENSURE THAT YOU HAVE READ THE INFORMATION ENCLOSED IN THE REGISTRATION PACK WITH REGARDS TO ONLINE REGISTRATION

First Name: **Surname :**	**Date of Birth:** ____/__/____
Address:	
Email address:	

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

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my Summary of Medical Record	☐
Accessing my Detailed Coded Records – *Please ask at reception for full details how to register*	

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	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. 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	**Date**

For practice use only Patient NHS number	Practice computer ID number
Proof of Residence **Tenancy Agreement ☐** **Council Tax ☐** **Utility Bill ☐** ***RECEP PLEASE TICK ONE OF EACH***	
Photo ID **Driving Licence ☐** **ID Card ☐** **Passport ☐** ***RECEP PLEASE TICK ONE OF EACH***	
Authorised by	Date

Electronic Prescription Service

If you have nominated a Pharmacy previously using this system and then recently joined our Practice – please ensure that your nominated Pharmacy is up to date – either with the Practice or your new Pharmacy of your choice.

For more information on the Electronic Prescription Service visit – www.connectingforhealth.nhs.uk/eps

If you wish to use the Electronic Prescription Service – please ask at your local Pharmacy or at Reception at Clarendon Lodge.

Please complete the Nomination form below to enable us to update your records if you wish to use this service.

Nomination Form for Electronic Prescriptions

Name …… Date of Birth……

Address ……

Nominated Pharmacy/ Name of pharmacy

……..

Address of Pharmacy :

…….

Post Code of Pharmacy ……

Signed: …… Date ……...