New Patient Registration Form - Age 0-16 Ash Grove Medical Centre - October 2019

Please complete all pages in full using block capitals

**In order to process your application form we require a copy of your Birth Certificate**

## 1. Background Details

| **Contact Details** | | | |
|---|---|---|---|
| Name | | Gender | |
| 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: | | |
| Parent / Guardian | Name: Tel: Relationship: | | |

** 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 or health campaigns or Patient Participation Group details.*

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

| **Other Details** | | | | |
|---|---|---|---|---|
| Previous GP | Name: Address: | | | |
| Country of Birth | | | | |
| Ethnicity | ☐ White (UK) | ☐ Black Caribbean | ☐ Bangladeshi | ☐ Arabic |
| | ☐ White (Irish) | ☐ Black African | ☐ Indian | ☐ Chinese |
| | ☐ White (Other) | ☐ Black Other | ☐ Pakistani | ☐ Other |
| Religion | ☐ C of E | ☐ Buddhist | ☐ Sikh | ☐ No religion |
| | ☐ Catholic | ☐ Hindu | ☐ Jewish | ☐ Other: |
| | ☐ Other Christian | ☐ Muslim | ☐ Jehovah's | |

| **Communication Needs** | | | | | |
|---|---|---|---|---|---|
| Language | What is your main spoken language? | | | | |
| | Do you need an interpreter? | | | ☐ Yes | ☐ No |
| Communication | Do you have any communication needs? | | | ☐ Yes ☐ No | (if **yes** please specify below) |
| | ☐ Hearing Aid | ☐ Large print | ☐ British Sign Language | | |
| | ☐ Lip reading | ☐ Braille | ☐ Makaton Sign Language | ☐ Guide dog | |

| **Carer Details** | | | | |
|---|---|---|---|---|
| **Are you** a carer? | ☐ Yes - informal/unpaid carer | ☐ Yes - Occupational/paid carer | ☐ No | |
| Do you **have** a carer? | ☐ Yes | Name*: Tel: | Relationship: | |

**Only add carer's details if they give their consent to have these details stored on your medical record*

## 2. Medical History

### Medical History

Have you suffered from any of the following conditions?

- ☐ Asthma
- ☐ COPD
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Heart Failure
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Depression
- ☐ Underactive Thyroid
- ☐ Cancer - Type:

Any other conditions, operations or hospital admission details:

If you are currently under the care of a Hospital or Consultant outside out area, please tell us here:

### 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

- ☐ Asthma
- ☐ COPD
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Stroke
- ☐ Blood Pressure
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Depression
- ☐ Thyroid
- ☐ 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

## 3. Further Details

| Electronic Prescribing | |
|---|---|
| If you would like your prescriptions to go electronically, please provide details of the pharmacy you would like to use | Pharmacy: |

| 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.*

| Organ Donation | |
|---|---|
| Blood Donation | ☐ I am already a blood donor<br>☐ I wish to be a blood donor<br>☐ I do not wish to be a blood donor |
| Organ Donation | ☐ I am already registered as a donor<br>☐ I wish to be a donor - all body parts<br>☐ I wish to be a donor - for these body parts:<br>☐ I do not wish to be a donor<br><br>To register: Online: www.blood.co.uk/the-donation-process/recognising-donors<br>Telephone: 0300 123 23 23 to speak to an advisor who will send out a donor card |

| Signature | |
|---|---|
| Signature | I confirm that the information I have provided is true to the best of my knowledge<br>☐ Signed on behalf of the patient |
| Name | |
| Date | |

### Checklist

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

- ☐ Completed and signed above form
- ☐ Completed and signed GMS1 Form
- ☐ Photo Proof of ID Birth Certificate

**Practice Use Only**

| | | | | |
|---|---|---|---|---|
| Appointment | ☐ Required | ☐ Not Required | | |
| Photo ID | ☐ Passport | ☐ Driving licence | ☐ Identity card | ☐ Other |
| Proof of Address | ☐ Utility Bill | ☐ Council Tax | ☐ Bank Statement | ☐ Other |
| GP Code | | | | |

## 4. Sharing Your Health Record

### Your Health Record

Do you consent to your GP Practice sharing your health record with other organisations who care for you?

☐ Yes *(recommended option)*

☐ No

Do you consent to your GP Practice viewing your health record from other organisations that care for you?

☐ Yes *(recommended option)*

☐ No

### Your Summary Care Record (SCR)

Do you consent to having an Enhanced Summary Care Record with Additional Information?

☐ Yes *(recommended option)*

☐ No

### Signature

| | |
|---|---|
| Signature | ☐ Signed on behalf of the patient |
| Name | |
| Date | |