

New Patient Registration Form (Adult: 16 and over)



Instructions for completing this form

1. Complete a separate form for each family member to be registered
2. Complete in BLOCK CAPITALS and tick the boxes as appropriate

Please fully complete this questionnaire as missing information can result in a delay of your registration

1	Full Name:				Date of Birth:	
	Title :	<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other. <i>Please state :</i>
	Other. <i>Please state :</i>				Marital Status:	
	Mobile tel. number:				Maiden name / Mothers name if different:	
	We will use this to send appointment reminders and health promotion details. Please tick here to give your consent for this: <input type="checkbox"/>				Current Address:	
	Work tel. number:				E-mail address:	
	Next of Kin:				Next of Kin contact tel. number:	
	Relationship to Patient:					
	Please indicate your first choice of contact method:					
<input type="checkbox"/> Letter <input type="checkbox"/> Email <input type="checkbox"/> SMS (text) <input type="checkbox"/> Phone						
Town* and Country of birth		Country:		Borough (*If born in London):		
(*If town is London please state which Borough)		Town:				
Please list other relatives of your home who are registered with us:						
Relationship:		Name:		Date of Birth:		













2	Looking After Someone	
	Are you looking after someone? Let us know if you are looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems.	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Is someone looking after you? Let us know if a family member, friend or neighbour looks after you. If yes, they are your carer. You are welcome to invite your carer to accompany you to visits at the practice.	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Carer's name :	Relationship to you:
Address of carer :		
Telephone number of carer :		

3	Are You Currently Employed?		
If so please specify whether :		<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time
		<input type="checkbox"/> Self-employed	
If you are not employed, please indicate which best describes you:			
<input type="checkbox"/> Retired	<input type="checkbox"/> Student	<input type="checkbox"/> Housewife/ Homemaker/House husband	<input type="checkbox"/> Unemployed
<input type="checkbox"/> Other <i>Please state:</i>			

4 Your Religion (Please tick) (*PS=please state)	<input type="checkbox"/> C of E	<input type="checkbox"/> Catholic	<input type="checkbox"/> Other Christian *PS_____	<input type="checkbox"/> Bhuddist	<input type="checkbox"/> Hindu	<input type="checkbox"/> Muslim
	<input type="checkbox"/> Sikh	<input type="checkbox"/> Jewish	<input type="checkbox"/> Jehovah's Witness	<input type="checkbox"/> No religion	<input type="checkbox"/> Other religion *PS_____	
Your Ethnic Origin (Please tick one)	<input type="checkbox"/> White (UK)		<input type="checkbox"/> White (Irish)	<input type="checkbox"/> White (Other)		
<input type="checkbox"/> Black Caribbean/British	<input type="checkbox"/> Indian/British Indian	<input type="checkbox"/> Arabic		<input type="checkbox"/> Other Mixed Background		
<input type="checkbox"/> Black African / British	<input type="checkbox"/> Pakistani <input type="checkbox"/> British Pakistani	<input type="checkbox"/> Chinese		<input type="checkbox"/> Other Asian Background		
<input type="checkbox"/> Other Black Background	<input type="checkbox"/> Bangladeshi / British Bangladeshi	<input type="checkbox"/> Other		<input type="checkbox"/> Ethnic Category Refused		
What is your main spoken language?			Do you need an Interpreter?			
Do you speak English? Yes <input type="checkbox"/> No <input type="checkbox"/>			Yes <input type="checkbox"/> No <input type="checkbox"/>			
Do you need help with mobility/hearing/speaking? (tick all that apply)						
<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Walking aid	<input type="checkbox"/> Hearing aid	<input type="checkbox"/> British sign language (BSL)	<input type="checkbox"/> Makaton sign language		
<input type="checkbox"/> Lip reading	<input type="checkbox"/> Large print	<input type="checkbox"/> Braille	<input type="checkbox"/> Other *PS_____			
Are you currently?	Homeless <input type="checkbox"/>	A Refugee <input type="checkbox"/>	An Asylum Seeker <input type="checkbox"/>			
Are you housebound?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Comments:				
If returning from the Armed Forces please state which below: Comments:						
<input type="checkbox"/> Army		<input type="checkbox"/> Royal Navy		<input type="checkbox"/> Royal Air force		

Please state any country (outside UK) that you have visited/lived in for more than 6 months during the past 5 years	
Country:	Dates/Year (If known):

5	Diet and Exercise		What type of diet do you have?	
	How much exercise do you do?		<input type="checkbox"/> Healthy	
	<input type="checkbox"/> Sedentary (No exercise)		<input type="checkbox"/> Unhealthy	
	<input type="checkbox"/> Gentle (climbs stairs, walking , gardening)		<input type="checkbox"/> Vegan	
	<input type="checkbox"/> Moderate (Cycling, swimming regularly)		<input type="checkbox"/> Vegetarian	
	<input type="checkbox"/> Vigorous (Attends gym regularly)		<input type="checkbox"/> Moderate	
Please enter your height in		Please enter your weight in		
Feet / inches:	cm:	Kilos/grams:	Stones / lbs:	

6	Lifestyle		
	Are you currently a smoker?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If you smoke, how many Cigarettes / Cigars / Tobacco do you smoke in a day?
	Have you ever been a smoker?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	If you are a smoker and want to STOP please tick here: <input type="checkbox"/>		
	Alcohol	Alcohol consumption is measured in units, which is explained in the diagram below.	
<p>This is one unit...</p> <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> Half pint of regular beer, lager or cider</div> <div style="text-align: center;"> One very small glass of wine</div> <div style="text-align: center;"> One single measure of spirits</div> <div style="text-align: center;"> One small glass of sherry</div> <div style="text-align: center;"> One single measure of aperitifs</div> </div> <p>...and each of these is more than one unit...</p> <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> A pint of regular beer, lager or cider 2</div> <div style="text-align: center;"> A pint of premium beer, lager or cider 3</div> <div style="text-align: center;"> Alcopop or a can/bottle of regular lager 1.5</div> <div style="text-align: center;"> 440ml can of premium lager or strong beer 2</div> <div style="text-align: center;"> 440ml can of super strength lager 4</div> <div style="text-align: center;"> 175mm glass of wine 2</div> <div style="text-align: center;"> Bottle of wine 9</div> </div>			
Please have a look at the above diagram and then answer the questions on the next page.			

Total AUDIT Score (Questions 1 – 10):

Questions about your Alcohol Consumption	Scoring System					Your score
	0	1	2	3	4	
1. 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	
2. 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+	
3. 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	
If your total score for the above 3 questions is 4 or less, then you do not need to complete the questions below						
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	
5. 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	
6. 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	
7. 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	
8. 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	
9. Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. 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 the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence.

7	Women Only	What is the date of your last Smear test ?	Date:	Result:
	Was this at your GP Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last Mammogram (if applicable):	
	Number of pregnancies (include miscarriages & terminations) (If applicable)			
	Do you wish to see a doctor in this Practice for contraceptive services (including the pill, coil or cap)?			

8	Your Medical Background			
Are there any serious diseases that affect your parents, brothers or sisters? Tick all that apply and state family member:				
<input type="checkbox"/> Diabetes Who:	<input type="checkbox"/> Asthma Who:	<input type="checkbox"/> Thyroid disorder Who:	<input type="checkbox"/> Stroke Who:	<input type="checkbox"/> COPD Who:
<input type="checkbox"/> Heart Attack under age of 60 Who:	<input type="checkbox"/> Cancer (Specify type) Who:	<input type="checkbox"/> High Blood pressure Who:	Any other important family illness. Please state: (angina, epilepsy, dvt, etc)	Who:
Please state any allergies and sensitivities you have to medicines, food & dressings:				
Please state any mental disabilities you have:				
Are you able to administer your own medicines?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no please give details, e.g. swallowing or opening containers:		
What long term medical conditions have you had?				Date of Diagnosis:
What operations or serious injuries have you had?				Date of operations or injuries:
<p>Please list any tablets, medicines or other treatments you are currently taking / undertaking:</p> <p>If you do not complete this section and you are on repeat medication, there might be a delay in us being able to issue your next repeat prescription.</p>				
We can now send your prescriptions electronically to the pharmacy of your choice. If you would like us to do this, please give the name and location of the pharmacy here:				

9	Sharing Your Medical Record
<p>Medical Record Sharing allows your complete GP medical record to be made available to authorised healthcare professionals involved in your care. You will always be asked your permission before anybody looks at your shared medical record.</p> <p>If you don't want to share your GP record tick here: <input style="float: right;" type="checkbox"/></p>	
<p>Summary Care Record contains details of your key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. You will always be asked your permission before anybody looks at your Summary Care Record.</p> <p>If you don't want to have a Summary Care Record tick here: <input style="float: right;" type="checkbox"/></p>	

10	Patient Participation Group (PPG)
<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. By expressing your interest, you will be helping us to plan ways of involving patients that suit you. It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.</p> <p>If you are interested in getting involved in the PPG, please tick yes in the box below and we will contact you with further details.</p>	
<p>Yes I am interested in becoming involved in the PPG <input style="margin-left: 10px;" type="checkbox"/> No I am not interested in becoming involved in the PPG <input style="margin-left: 10px;" type="checkbox"/></p>	

11	Online Services
<p>You can now do the following online or via the SystmOnline app:</p> <ul style="list-style-type: none"> • Book and cancel appointments, order repeat prescriptions, view your Detailed Medical Record. <p style="text-align: center; font-size: small; margin-top: 10px;">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.</p>	
<p>Yes I'd like to register for online services <input style="margin-left: 10px;" type="checkbox"/> No I don't want to register for online services <input style="margin-left: 10px;" type="checkbox"/></p>	

12	Other Information	
<p>Do you have a "Living Will" or "Advanced Directive"? (A statement explaining what medical treatment you would not want in the future)?</p>		<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "Yes", can you please bring a written copy of it to your first appointment?</p>
<p>Have you nominated someone to speak on your behalf (<i>e.g. a person who has Lasting Power of Attorney</i>)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>		<p>If "Yes", please state their</p> <p>Name:</p> <p>Address:</p> <p>Phone number:</p>

CHECKLIST

Thank you for completing this form. Please check you have completed all sections where possible.
Please ensure that you bring the following with you to the surgery to complete your registration:

- | | |
|--|--|
| <ol style="list-style-type: none"> 1. Completed & Signed New Patient Registration Questionnaire (this form!) 2. Completed & Signed GMS1 Form 3. Photo Proof of ID - e.g. Passport, Photo Driving License or Photo ID card 4. Proof of Address – <i>Must be in your name and dated within the past 3 months</i>
– <i>Provided in one of the following:</i> Bank statement, Utility Bill (Gas, Electricity, Water), Council Tax, Tenancy Agreement or Landline Phone Bill (Mobile phone bills are not accepted) 5. If possible, your Immunisation Records – usually the Personal Child Health Record (“Red Book”) 6. If possible, your NHS Card – usually shows your previous GP and your NHS Number 7. If relevant, your Repeat Medication Request Slip from your previous GP | <input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/> |
|--|--|

- **Please book a New Patient appointment if you are on any regular medication or have any chronic or significant medical condition**
- **Please request a copy of the Practice Leaflet if you have not already received it. Alternatively you can also find more information on our practice website**
- **I confirm that I have completed this form as accurately and honestly as possible and would like to apply to be registered as a patient at this practice**

13	Signature	Date:
	Patient signature:	Signature if signing on behalf of patient:

OFFICE USE ONLY	Need Appt? <input type="checkbox"/> Yes <input type="checkbox"/> No	Need Etoh Advice? <input type="checkbox"/> Yes <input type="checkbox"/> No	Staff Initials:
Photo ID	<input type="checkbox"/> Passport	<input type="checkbox"/> Driving licence	<input type="checkbox"/> Identity card
Proof of Address	<input type="checkbox"/> Utility Bill	<input type="checkbox"/> Tenancy Agreement	<input type="checkbox"/> Bank Statement
Nominated GP	<input type="checkbox"/> Patient advised		<input type="checkbox"/> Patient not advised (add reminder to record)