

# 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


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

<b>2</b>	<b>Looking After A Family Member</b>	
	<b>Are you looking after someone?</b> 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	
	<b>Is someone looking after you?</b> 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	
	<b>Carer's name :</b>	<b>Relationship to you:</b>
<b>Address of carer :</b>		
<b>Telephone number of carer :</b>		

<b>3</b>	<b>Are You Currently Employed?</b>			
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>				
<b>Which of the following best describes how you think of yourself?</b>  <input type="checkbox"/> Woman (including trans woman) <input type="checkbox"/> Man (including trans man) <input type="checkbox"/> Non-binary <input type="checkbox"/> In another way, please state .....  <input type="checkbox"/> Lesbian/ Gay <input type="checkbox"/> Heterosexual / Straight <input type="checkbox"/> Bisexual <input type="checkbox"/> In any other way (please state) .....			<b>Is your gender identity the same as you were given at birth?</b>  Yes <input type="checkbox"/> No <input type="checkbox"/>	
			<b>Chelsea falls within a high-risk area for HIV infection.</b> <b>Would you like to receive a free HIV test?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	

<b>4</b>	<b>Your Religion</b> (please state): It's important to let us know if your religion will affect any treatment you receive			
<b>Your Ethnic Origin</b> (Please tick one)				
<input type="checkbox"/> Black Caribbean/British	<input type="checkbox"/> Indian / British Indian	<input type="checkbox"/> Arabic	<input type="checkbox"/> White (UK)	
<input type="checkbox"/> Black African /British	<input type="checkbox"/> Pakistani / British Pakistani	<input type="checkbox"/> Chinese	<input type="checkbox"/> White (Irish)	
<input type="checkbox"/> Other Black Background	<input type="checkbox"/> Bangladeshi / British Bangladeshi	<input type="checkbox"/> Other	<input type="checkbox"/> White (Other)	
<input type="checkbox"/> Other Mixed Background	<input type="checkbox"/> Other Asian Background		<input type="checkbox"/> Ethnic Category Refused	
<b>Do you need an Interpreter?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, which language:</b>				
<b>Do you need help with mobility/hearing/speaking?</b> (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, Please state:	
<b>Are you currently?</b>	<input type="checkbox"/> Homeless	<input type="checkbox"/> A Refugee	<input type="checkbox"/> An Asylum Seeker	
<b>Are you an 'Assistance Dog' User?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Are you housebound?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No		


<b>5</b>	<b>Lifestyle</b>			
<b>Are you currently a smoker?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		If you smoke, how many Cigarettes / Cigars / Tobacco do you smoke in a day?		
<b>Have you ever been a smoker?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
If you are a smoker and want to STOP please tick here: <input type="checkbox"/>				
<b>Alcohol:</b>		Scoring System		

		0	1	2	3	4	5	 <small>Central London, West London, East London, South London, North London, London Boroughs, London Fringe, London Underground Districts</small> Four <b>Score</b>
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+ if male, on a single occasion in the last year?	Never	Less Than Monthly	Monthly	Weekly	Daily Or Almost Daily			
*Alcohol Units: 1 Pint Of Premium Beer = 2.5 Units. 1 Pint Beer/Cider = 2 Units. Single Measure Of Spirit = 1 Unit. Small (125ml) Glass Of Wine = 1 Unit								<b>Total Score</b>

6	<b>Diet and Exercise</b>			<b>What type of diet do you have?</b>		
	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:	

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

8	<b>Your Medical Background</b>					
	Are there any serious diseases that affect your parents, brothers or sisters? Tick all that apply <u>and</u> 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. <u>Please state:</u> 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		<i>If no</i> 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:

<b>9</b>	<p><b>Sharing Your Medical Record</b></p> <p><b>Medical Record Sharing</b> 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.  <b>If you don't want to share your GP record tick here:</b> <input type="checkbox"/></p> <p><b>Summary Care Record</b> contains details of your key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&amp;E Departments throughout England. You will always be asked your permission before anybody looks at your Summary Care Record.  <b>If you don't want to have a Summary Care Record tick here:</b> <input type="checkbox"/></p> <p><b>The Care.data Programme</b> Collates information about you and the care you receive. It links information from all the different places where you receive care, such as your GP, hospital and community services, to help them provide a full picture of your medical needs and the care you are receiving. This data is made available to NHS Commissioners so that they can design integrated services and is shared with third parties for research purposes.  <b>I wish to OPT OUT from my Personal Confidential Data being shared outside my GP practice:</b> <input type="checkbox"/>  <b>I wish to OPT OUT from my Personal Confidential Data being shared with <i>third parties</i>:</b> <input type="checkbox"/></p>
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<b>10</b>	<p><b>Patient Participation Group (PPG)</b></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. 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.          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><b>Yes</b> I am interested in becoming involved in the PPG <input type="checkbox"/>      <b>No</b> I am not interested in becoming involved in the PPG <input type="checkbox"/></p>
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<b>11</b>	<p><b>Online Services</b></p> <p>You can now do the following online or via the SystemOnline app:</p> <ul style="list-style-type: none"> <li>Book and cancel appointments, order repeat prescriptions, view a summary of your medical record.</li> </ul> <p>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><b>Yes</b> I'd like to register for online services <input type="checkbox"/>      <b>No</b> I don't want to register for online services <input type="checkbox"/></p>
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<b>12</b>	<p><b>Other Information</b></p> <table border="1" data-bbox="151 1814 1572 1904"> <tr> <td data-bbox="151 1814 829 1904">Do you have a "<b>Living Will</b>"? (A statement explaining what medical treatment you would not want in the future)?</td> <td data-bbox="829 1814 1077 1904"> <input type="checkbox"/> Yes  <input type="checkbox"/> No         </td> <td data-bbox="1077 1814 1572 1904"><b>If "Yes"</b>, can you please bring a written copy of it to your first appointment?</td> </tr> </table> <p>Have you nominated someone to speak on your behalf (<b>e.g. a person who has Power of Attorney</b>)?  <input type="checkbox"/> Yes</p> <p><b>If "Yes", please state</b> their          Name:          Address:          Phone number:</p>	Do you have a " <b>Living Will</b> "? (A statement explaining what medical treatment you would not want in the future)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If "Yes"</b> , can you please bring a written copy of it to your first appointment?
Do you have a " <b>Living Will</b> "? (A statement explaining what medical treatment you would not want in the future)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If "Yes"</b> , can you please bring a written copy of it to your first appointment?		

No



**13 Signature**

Patient signature:

Signature on behalf of patient:

**Thank you for completing this form. *For more information about the services we offer, please refer to our practice leaflet or see our website***