**NEW PATIENT INFORMATION SHEET**

New patients will be asked to produce a document to prove personal and residential identification when registering.

This should be one of the following:-

Birth Certificate Medical Card Valid Driving Licence Passport

In addition, proof of address:- Phone or utility bill

**If you do not keep your first appointment with the nurse for your medical, you won’t be booked in again**

**NEW PATIENT QUESTIONNAIRE- please use capitals**

Title: Surname: First Names: Previous Surname Date of Birth:

**NHS number**

Full Address:

Post Code: Telephone

Place of Birth:

Email address

Marital Status: Male/Female Occupation:

Previous address:

Previous Postcode: Previous GP name:

Please nominate a pharmacy for prescriptions to be sent to: ……………………………………….

If from abroad, date of leaving UK if applicable: …………………. Entered UK: ………….……….

If previously with the Services, date of discharge: ……………………………………………………..

Email address: ……………………………………………………………………………………………

ETHNIC ORIGIN: British Other *(please specify)* ……………

FIRST LANGAUGE: English Other *(please specify)* ……………

GENERAL HISTORY:

What medicines are you taking – please bring in your current repeat slip if you have one. ………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………………………………………………………………………………………………………

***If you are on medication, you will need to see the doctor before your prescription is issued***

Have you any allergies to medicines or anything else? ………………………………………………

………………………………………………………………………………………………………………

Who is your next of kin (name and tel no.)?..................................................................................

If you have a carer, who are they (name and tel no.)?..................................................................

Are you are a carer? …………………………………………….........................................................

**Have you ever been in the armed forces yes / no …………………………………… (Details)**

How often do you have a drink containing alcohol? *(please circle)*

*Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week*

How many alcoholic drinks do you have on a typical day? *1-2 3-4 5-6 7-9 10+*

How often do you have 6 or more drinks on one occasion?

*Never Less than monthly Monthly Weekly Daily / almost daily*

How much tobacco or cigarettes do you smoke? ……………………….………………….. per day

Or: I have never smoked (*please tick)*  Or: I gave up in …………………..

*If you would like to give up smoking, please ask for details of quit smoking support.*

FAMILY HISTORY: Which of your blood relations have suffered one of the following:-

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Mother | Father | Brother / sister | Aged |
| Heart disease / attack |  |  |  |  |
| Cancer |  |  |  |  |
| Diabetes |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| Asthma |  |  |  |  |
| TB |  |  |  |  |
| Stroke |  |  |  |  |
| Other Serious Illness |  |  |  |  |

ALL PATIENTS:

I confirm that the information given is true to the best of my knowledge

Signed: Date:

**PATIENT CONSENT FORM**

Consent to hold, process and share manual and electronic records and data in accordance with the Data Protection Act 2018, the Caldicott Report, and other relevant Information Governance legislation.

When you are registered at the practice, your details will be shared, as appropriate:

* With members of the practice health care team
* With other healthcare professionals involved in my care
* For the purposes of practice administration

I give my informed consent for Croft Surgery to hold, process and share my personal and medical records, manually and electronically, as outlined below:-

**YES / NO**

Locally for the purposes of the Local Shared Electronic Record (CHIE) and Hub

for my direct health care

**YES / NO**

Nationally for the purposes of National Shared Electronic Record (SCR) for my

direct health care

**YES / NO**

Nationally for the purposes of improving and planning the health and care of

current and future generations (indirect health care)

Patient’s name (if consenting for a child under 13)

Your Name: (print)

Signed:

Date:

Please note – We use a company called Docmail to send letter invites to patients (for example flu invites). We also use a company called MJog to send text reminders to patients (for example, appointment reminders). We have gained approval from the CCG to use these companies and we are confident your data is secure. If you have any concerns regarding this, please speak to the Practice Manager.

By providing your contact details, you are consenting to us using them to contact you by post, telephone, email or SMS (text).

We do not share your data for the purposes of education, research, audit or administration without your express consent (i.e. we would ask you every time for permission before doing this). The only exception to this would be where the data was anonymised, i.e. not identifiable back to you.

**The Accessible Information Standard (SCCI 1605)**

IN accordance with the accessible information standard, please accept the below as formal notification of my information and communication preferences

I communicate using (eg BSL< deaf blind manual )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To help me communicate I use (eg talking mat, hearing aids)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I Need information in (eg braille, easy read)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you need to contact me the best way is (eg email, telephone, text) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Appointments & Prescriptions Online**

You can now book, cancel and view your appointments, as well as ordering your repeat medication online. This service is provided through our Clinical Software Supplier (Emis), and is called Patient Access.

If you are interested in this service, you will need to complete the registration Form below and come to the surgery with an appropriate form of photo ID **(such as a Passport or Driving License).** *Please note: each family member 13 and over will need to visit the surgery with their own Photo ID,* ***they will also need their own email address.***

Once registered, we will send you an e-mail within 28 days, with information that will enable you to create a Patient Access account and link it to the surgery.

Please complete the form below **clearly** and in **BLOCK CAPITALS.**

**I wish to register for** Patient Access**:**

|  |  |
| --- | --- |
| **Forename:** | **Surname:** |
| **Date of Birth:** |  |

*Parents / guardians can register on behalf of their children under 13. However, when a child turns 13, they will be automatically de-registered and written to explaining why. They will then be able to re-register using their own contact details, or should they choose to, their parent / guardian’s email address.*

|  |  |
| --- | --- |
| **Email address:** | **Home telephone number:** |
| **Mobile telephone number:** | **Work telephone number:** |

*By providing your email address / mobile phone number, you consent to the surgery using it to communicate with you regarding your healthcare. It will not be shared with any other companies, and you can opt out of* Patient Access *and communication by email / SMS at any time by contacting the surgery.*

*The surgery does not recommend that patients use a shared email address / mobile phone number – you will be sent appointment booking and prescription confirmation emails, which may be confidential to the individual. By choosing to use a shared email address / mobile phone number, you confirm that you are aware of this issue and accept the consequences. For more information, please contact the surgery.*

**PLEASE REMEMBER IT IS YOUR RESPONSIBILITY TO KEEP US INFORMED IF YOUR EMAIL ADDRESS OR TELEPHONE NUMBERS CHANGE.**

|  |  |
| --- | --- |
| **Signed** | **Date** |
|  |  |

**Staff Use Only:**

|  |  |  |
| --- | --- | --- |
| **Type of ID Seen** | **ID Seen By** | **Date ID Seen** |
|  |  |  |