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| **PATIENT NAME (CAPITALS):****Walford Mill Medical Centre****Knobcrook Road, Wimborne, Dorset, BH21 1NL****(01202) 886999****Walford.mill@nhs.net****New Patient Registration Form****C:\Users\Reception\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\PJJ45M3D\853px-Stub_doctors.svg[1].png****For reception use only*** SCR consent checked signed
* Signature
* Dr assigned and patient informed. Initials of GP …………………….
* Online services ID if required (sign-in within 48 hrs of receiving logon details)

Type of ID……………………………………* New patient information pack given to patient

Registration form checked by…………………………………………(PST Staff Name)Date…………………………………… Walford Mill Medical Centre |

**Do you have any special communication needs?** 🞏 YES 🞏 NO

**Do you require an interpreter?** 🞏 Yes 🞏 No

If YES, please state what you need below i.e. sign language or LARGE PRINT

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

*(Should your needs change, please inform reception as soon as possible to ensure your records are updated)*

**CONFIDENTIAL MEDICAL REGISTRATION FORM**

**Please complete all pages in FULL using BLOCK capitals**

Surname:

First Names (in full):

Previous Surnames (If applicable):

Title: 🞏 Mr 🞏 Mrs 🞏 Miss 🞏 Ms 🞏 Master 🞏Other …………………………………

🞏 Male 🞏 Female 🞏 Prefer not to specify

Date of Birth: NHS Number (if known):

Town & Country of Birth:

 Post Code:

Current Address:

Telephone number: Mobile number:

**Please state which number you would prefer to be contacted on in the first instance :**

🞏 Home 🞏 Mobile

Email address:

Are you happy for Walford Mill Medical Centre to contact you by the following:

By email 🞏 Yes 🞏 No

By text 🞏 Yes 🞏 No

**Please help us trace your previous medical records by providing the following information:**

Your previous address in UK:

 Post Code:

Name & address of previous Doctor while at that address:

 Post Code:

**If you are from abroad:**

Your first UK address where

 Post Code:

registered with a GP:

If previously living in the UK, Date you first

date of leaving: came to UK:

**If you are returning from the Armed Forces:**

Address before enlisting:

 Post Code:

Enlistment date: Service/ Personnel number:

**Please tell us about yourself:**

1. Are you a military veteran? 🞏 Yes 🞏 No
a. Are you living as part of a military family? 🞏 Yes 🞏 No

b. Are you currently under any specialist or hospital care outside of Dorset? 🞏 Yes 🞏 No

If yes, please provide information………………………………………………………………………………………………………..

……………………………………………………………………………………………………………………..

Information for military families on NHS services can be found with the following link:

https://www.nhs.uk/nhs-services/armed-forces-community/nhs-services-guide/

1. Are you a carer? 🞏 Yes 🞏 No
2. Do you have a carer? 🞏 Yes 🞏 No

If yes, please tell us the name, address &

telephone number of your carer *or*

who you care for:

Are you happy for us to contact your carer 🞏 Yes 🞏 No

about you if necessary?

**Ethnicity**

**vej**

🞏 British or mixed British 🞏 Irish 🞏 African 🞏 Caribbean 🞏 Indian 🞏 Pakistani

🞏 Bangladeshi 🞏 Chinese 🞏 Other (please state):

🞏 Prefer not to state

Medical history (please tick all current or past illnesses):

🞏 Heart Disease/Angina 🞏 Diabetes 🞏 COPD

🞏 High blood pressure 🞏 Stroke/TIA 🞏 Hypothyroidism

🞏Asthma 🞏 Cancer 🞏 Dementia

🞏 Osteoporosis 🞏 Rheumatoid Arthritis 🞏 Epilepsy

🞏 High Cholesterol 🞏 Other *(state on line below)*

…………………………………………………………………

Do you have any allergies? 🞏 Yes 🞏 No

If yes, please provide further details: …………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Please provide details of any medication you take **or** attach a repeat prescription from your previous GP to the form:

Name of medication: Dose:

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

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

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

Do you have a disability? 🞏 Yes 🞏 No

If yes, please provide further details: ………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Next of kin**

**vej**

Name: Contact number:

Relationship to you:

Address if different from patient: …………………………………………………………………………………………………………..

…………………………………………………………………………………………………………..

**NHS Organ Donor Registration**

All Adults are now automatically opted into the Organ Donation Programme.

For further information or to opt out please go to: [www.organdonation.nhs.uk](http://www.organdonation.nhs.uk) or telephone 0300 123 23 23

**Lifestyle**

Do you smoke? 🞏 Yes 🞏 No

If yes, how many per day? 🞏 1-9/day 🞏 10-19/day 🞏 20-39/day 🞏 40+/day

Would you like help to quit? 🞏 Yes 🞏 No

Are you an ex-smoker? 🞏 Yes 🞏 No

If yes, when did you give up?

What is your average alcohol consumption? ……………Units (per week)

(1 unit = ½ pint larger/cider, 1 single measure of spirit, 1, 125ml glass of wine)

What is your weight? …………….. .St/lb or …………………KG

What is your height? ……………....Ft/in or …………………CM

**If you have a cervix**

**vej**

Have you ever had a Cervical Smear? 🞏 YES 🞏 NO

If yes, please fill out below

When: …………………………………………..

Where: …………………………………………

Results - Normal 🞏 Abnormal 🞏

Are you currently pregnant? 🞏 YES 🞏 NO

If yes, please tell us your due date: ……………………………………….

**Pharmacy**

**vej**

Prescriptions are sent electronically to your pharmacy of choice. Please tell us which pharmacy you would like your prescriptions to go to:

Name ……………………………………………………………………………………….

Address ……………………………………………………………………………………………………..

Postcode ………………………………..

**Online access**

**vej**

* Do you require online access for prescription requests or booking appointments? 🞏 Yes 🞏 No

If yes, please bring in some photo ID (driving licence, passport, bus pass, etc) and you will be given a logon ID and password. You will need to go to our website and **log in within 48 hours** or the access will be rescinded.

* If you are requesting online access for a child (under 13) whom you have parental responsibility for, please state the name, date of birth and relationship of the person requesting access.

Name……………………………………………………………… Date of birth………………………… Relationship…………………………….

* If you are aged 13-15 you will require online access to your own record, please contact reception for information on a competency assessment (please see end of document for more info).

**Data sharing consent choices**

**vej**

To maintain continuity of clinical care, a basic summary of medications and allergies is uploaded to the summary care record. There is also an option to upload a summary of your heallth conditions and current care to better support others making healthcare decisions about you when the surgery is closed or when you are seen elsewhere e.g. emergency departments or out of hours servcies. Please see the enclosed privacy notice for more information and ensure you complete the consent form to turn this on or opt out.

**You must complete the data sharing form at the end of this registration before you can be registered at the practice.**

**Signature**

**vej**

I confirm that the information I have provided is true to the best of my knowledge:

Signed: ………………………………..……….. Date: …………………………

Signature of patient (if aged 16 or over) 🞏 Signature on behalf of patient 🞏

 Relationship to patient:…………………………….

**Please bring your completed registration form to the practice in person, along with 2 of the following:**

* Passport, driving licence, birth certificate, recent utility bill, bus pass.

If you do not have the identification documents above, please come and see us at reception with your form.

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| Walford Mill Medical Centre |

***Please read the attached privacy notice and complete the information below with your choices on sharing your data.***

**Data Sharing Form**

**Name**

**Date of Birth**

**Address**

**Summary Care Record**

This enables other healthcare services (e.g. emergency department, out of hours services) to view a summary of your medical history and current treatment.

🞏 **Yes –** I would like to consentfor medication, allergies, adverse reactions and additional information to be available on my summary care record for other healthcare professionals involved in my care

*Express consent for medication, allergies, adverse reactions and additional information (XaXbZ)*

🞏 **No –** I do not want other health professionals to see my healthcare information (Summary Care Record)

 *Express dissent for Summary Care Record (opt out) (XaXj6)*

🞏 **Or** – I would only like a list of medications and allergies available to other healthcare professionals. *Express consent for medication, allergies and adverse reactions only (XaXbY).*

**NHS National Data Opt Out**

The NHS collect information about patients when they use services to help with improving care, research and development of treatments and monitoring and planning. This is mainly anonymised however it is your choice if information is used in this way. If you choose to opt out use the online service or call 0300 3035678. Full details in the attached.

**Signed:**

Signature of patient 🞏 Signature on behalf of patient 🞏

(If aged 16 or over)Relationship to patient:………………………………….

**Date:**