

The surgery requires all patients to provide proof of ID AND ALSO PROOF OF ADDRESS to receive NHS medical services. This includes evidence of residence or right to residence and both may be requested.
The onus is on the patient. Occasionally, ongoing evidence may need to be produced to confirm status of residency.

|  |  |
| --- | --- |
| **Up to date proof of address ( Dated within the last 6 months)**  | **Proof of ID**  |
| Utility Bill | Passport  |
| Student Visa | Medical Card |
| Driving Licence  | Working Permit |
| Bank Statement  | Working Holiday Permit |
| Inland Revenue  | Benefits Documents |
| Ancestral Visa | Boarder Agency Application Reg Card |
| Occupancy Agreement  |  |

**PLEASE NOTE**

**The registration process takes 7-14 days. Anyone over the age of 5 will receive a letter to book in for a new patient check.**

**If you require medical attention before you are registered here you can either:**

 **- Contact your previous GP, if you are still registered.**

**- Contact the NHS 111 service and they can arrange relevant treatment from there.**

Please complete all questions on this form. **Incomplete forms may be returned to you, which will delay your registration.** This information remains confidential.

**Section 1**

Surname: Forenames:

Title: Mr/Mrs/Ms/Miss/Dr/Other: Date of Birth:

Marital Status: Maiden name (if applicable):

Address and postcode:

Mobile number: Home number:

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of birth (town and country):

**Next of Kin:** Relationship to you:

Their address and phone number:

**ABOUT YOU**

Do you have any allergies? **Yes/No** (delete as appropriate)

If yes please give details:

Ongoing medical problems: (please circle)

Asthma COPD Cancer Diabetes High Blood Pressure

Stroke Epilepsy Thyroid Disease Heart Disease Mental Health Illness

Other (please state):

**Current Medication (please list):** Please note, all medication will have to be brought with you when you attend for your new patient check.

Would you like future prescriptions to be sent to a nominated pharmacy? **Yes/No** (delete as appropriate)

If yes, please specify which pharmacy you would like us to send them to:

**This section helps us trace your medical records from your previous GP.**

Previous GP Surgery:

Address of previous GP surgery:

Your previous address while registered with this GP:

If you are from abroad, what date did you first enter the UK?

**SMOKING**

Do you smoke? **Yes/No** (delete as appropriate)

**If yes,** what do you smoke? Cigarettes/Cigars/Pipe (delete as appropriate)

Approximately how many do you smoke per day?

Do you wish to try to quit? **Yes/No** (delete as appropriate)

**If no**, have you ever smoked? If yes, when did you smoke and how many per day?

**Section 2**

**Family Medical History (please circle):**

Does any family member suffer with any of the following? (We only need to know Father, Mother, Brother or Sister)

Asthma COPD Cancer Diabetes High Blood Pressure

Stroke Epilepsy Thyroid Disease Heart Disease Mental Health Illness

**If yes, please indicate what condition and which family member:**

**Carers (delete as appropriate):**

Do you need / have anyone who looks after you or your daily needs? **Yes/No**

**If yes,** would you like them to deal with your health affairs here? **Yes/No**

Do you care for anyone else? **Yes/No**

**If yes,** ask receptionists about Carers support.

**Permission for family or carer to access medical Information**

By law your medical information is confidential to you and we will not give it out to other members or carers without your permission. If you would like a family member/carer to access your medical information please ask at reception for a permission form

**Females only:**

Are you currently pregnant? **Yes/No**

What form of contraception do you use? (If any)

Approximately when did you have your last smear test? Month: Year:

**Section 3**

**Ethnic Origin Monitoring** (please tick **only one** of the following).
*The Race Relations (Amended Act) 2000 requires all public authorities to take positive steps to promote race equality. The Grange Medical Centre is keen to promote racial equality in its work. That is why we are asking all patients registering with our practice to complete this ethnic monitoring form.*

**White:**( ) British (9i0) ( ) Irish (9i1)

**Mixed:**( ) White and Black Caribbean (9i3) ( ) White and Black African (9i4)

( ) White and Black Asian (9i5)

**Asian or Asian British:**( ) Indian (9i7) ( ) Pakistani (9i8)

( ) Bangladeshi (9i9)

**Black or Black British:**( ) Caribbean (9iB) ( ) African (9iC)

**Chinese:**( ) Chinese (9iE)

**Not stated: Any other not listed:**

( ) Not stated (9iG) Please give details:

**Section 4**

**We want to get better at communicating with our patients. We want to make sure you can understand the information we give you.**

In order for us to do this, please delete as appropriate.

Do you want the information we send you to be in large print or easy read? **Yes/No**

Do you need a British Sign Language interpreter or advocate? **Yes/No**

Do you need support in lip-reading or do you use a hearing aid or communication tool? **Yes/No** **If yes** please specify:

In order for us to treat you appropriately, please tell us the main language that you speak:

If English isn’t your main language, you require an interpreter? **Yes/No**

**Don’t hesitate to contact us if you find it hard to read or understand our letters or if you need someone to support you at appointments.**

**Please let receptionists know if you need information in a different format or if you need communication support.**

**ALCOHOL SCREENING**

Do you drink alcohol? **Yes/No** (delete as appropriate)

**If yes,** please answer the following questions and tick the best that applies to you:

1 drink = ½ pint of beer, 1 glass of wine or 1 single spirit

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **MEN:** How often do you have EIGHT or more drinks on one occasion?**WOMEN:** How often do you have SIX or more drinks on one occasion? | Never( )0 | Less than monthly( )1 | Monthly( )2 | Weekly( )3 | Daily or almost daily( )4 |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | Never( )0 | Less than monthly( )1 | Monthly( )2 | Weekly( )3 | Daily or almost daily( )4 |
| How often during the last year have you failed to do what was normally expected of you because of drinking? | Never( )0 | Less than monthly( )1 | Monthly( )2 | Weekly( )3 | Daily or almost daily( )4 |
| In the last year has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down? | No( )0 | Yes, on one occasion( )2 | Yes, on more than one occasion( )4 |  |  |
| **Total for each column:** | ( ) | ( ) | ( ) | ( ) | ( ) |
| **Total Score:** |  ( ) if score is >3 complete full audit  |

**Section 5**

**DECLARATION**

I declare that the above information is accurate and as up to date as possible. I understand that giving false information can delay my medical records being received from the Health Authority. It also constitutes an irrevocable breakdown in communication; this may lead to me being removed from the practice list.

Signature of patient: Date:

**It is a requirement of this practice that all patients over the age of 5 years are asked to attend a New Patient Check once they are registered with us (this is a 10 minute appointment with the Nurse)**