**New Patient Registration Form** 

Today’s date \* ……………………………………………………………………………………………………………………………………..

**Please complete this confidential questionnaire**

**Complete in BLOCK CAPITALS**

**A separate form must be completed for each family member**

For Office use only: Please tick to confirm identification seen Please tick if no identification available Completed by ……....

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| **Full Name:\*** | **Telephone numbers:\*****Home:** |
| **Mr / Mrs / Miss / Ms / Dr / \*****Other** ………………………………………… | **Mobile:** |
| **Work:** |
| **Address and Post Code:\*** | **E - mail address:** |
| **I consent to receive messages from Octagon Medical Practice for the purposes of health promotion, practice news and for appointment reminders:\*****By email Yes / No****By text Yes / No** |
| ***IF APPLICABLE – CARE HOME REGISTRATIONS\******Is this address for-****Residential Care? Yes / No****Nursing Care? Yes / No** | **Next of Kin name and Contact Details :** |
| **Are you a Carer?\*****Yes / No**(If yes please ask for a carers form to complete) |
| **Date of Birth:\*** | **Previous surname:\*** | **NHS Number:** |
| **Town and Country of birth:\*** | **Marital Status:** | **Occupation** |
| **Gender:\*****Male / Female / prefer not to say** | **Are you? A Military Veteran\*** **Yes/ No****A Military reservist\* Yes / No****A member of a Military Family\*****Yes / No** | **If applicable the date you first came to live in the UK:\*** |

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| **Previous Doctors name and address:\*** |
| **Your height: CM: ………………………………………………… Your weight: KG: ……………………………………………** |
| **Are you currently a smoker? \*** | **Yes** | **No** | **If yes how many cigarettes / cigars / or how much tobacco do you smoke in a week?**  |
| **Have you ever been a smoker?\*** | **Yes** | **No** | **When did you stop smoking?** |
| **Do you drink alcohol, how much per week?** \* |
| **Do you exercise? \*****How many times a week?.......................................... Type of Exercise? …………………………………………………………...** |

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| **Please list any tablets, medicines or other treatments you are currently receiving.****(including dose and frequency) Please supply your most recent repeat prescription list if possible.\*** |  |
| **Are there any serious illnesses that affect your family?\*** | **Diabetes** | **Heart Attack** | **High Blood pressure** | **Stroke** | **Thyroid Disorder** |
| **Bowel Cancer** | **Breast Cancer** | **Ovarian cancer** | **Asthma** |  |
| **Any other important family illness?** |
| **Specific needs:\*****Please detail below any specific needs you have so that the Practice can ensure they are identified and accommodated by taking the appropriate action:**(e.g. problems with your sight or hearing, require a translator, learning disabilities, physical disabilities etc )**Your health record and sharing of information\* –****Sharing out** – this controls whether your information recorded at this Practice can be shared with other healthcare professionals. **Sharing in –** This determines whether or not this Practice can view information in your record that has been entered by other services who are providing care for you, or who may provide care for you in the future.**The choices you would like to make about sharing your health record, please indicate below your choices.****Sharing out -**  I would like my health record at this Practice to be shared with other healthcare services providing care for me **YES / NO** **Sharing in –** I would like this Practice to be able to view information in my health record that has been recorded by other healthcare services **YES / NO****My choices apply to my records here at Octagon Medical Practice.** **Please indicate the Ethnic group to which you feel you belong:\*** **White** * British
* Irish
* Any white background

 **Mixed*** White and Black Caribbean
* White and Black African
* White and Asian
* Any other mixed background

 **Asian or Asian British*** Indian
* Pakistani
* Bangladeshi
* Chinese
* Any other Asian background

 **Black or Black British*** Caribbean
* African
* Any other black background

 **Other Ethnic Groups*** Arab
* Any other ethnic group

Is English your first Language **Yes / No**If English **is not** your first Languageplease state the language you speak below: |
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| **Named GP**From 1 April 2015 all practices are required to allocate a named accountable GP to all patients.Once we have completed your registration you may ask at reception who your named GP is.You remain free to see any GP for your consultations. |

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| **Patient Participation Group**We have our own patient participation group. All registered patients are welcome to join the group, whether you want to come along to a meeting or be involved only in a "virtual" group which communicates by email.If you want to be part of the group please ask for details. |

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| **AS A NEW PATIENT PLEASE USE THESE HELPFUL HINTS TO ENABLE YOU TO GET THE MOST FROM YOUR CONSULTATION*** Please remember you are a new patient, we have yet to get to know you and your medical history. Eventually if you have ever been registered with another surgery in the UK, your medical records will be sent to us, but until they arrive we need your help to be able to treat you appropriately.
* If you already take medication, and need some more tablets or other please bring in the containers this information will be helpful. Remember to bring details of when you first started on this medication and how often you take it.
* Be prepared, time with any Doctor or Nurse is limited. Write down what you want to tell the Doctor or Nurse and what you want to ask, this will help you and remind you of any issues you want to raise.
* If you think you may have difficulties understanding what the Doctor or Nurse tells you, or you may have difficulties getting into or out of the building, then please do bring someone along with you, to help you.
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