

FOR RECEPTION USE ONLY		FOR RECEPTION USE ONLY	
EMIS NUMBER:		Family members	
REGISTERED GP:		Appointment booked with GP	
PHOTO ID VERIFIED:			
PROOF OF ADDRESS:		CHILD REGISTRATION FORM 0-16 YEARS	

PAVILION SURGERY

2-3 Old Steine,
Brighton,
BN1 1EJ

<https://www.pavilionsurgery.co.uk/>

Supplying this information gives consent for us to contact you where medically necessary

Please confirm we have your permission to telephone, text or email you regarding your direct care (please circle):

YES

NO

Title: (Mr, Miss, Mrs, Ms, Mx, Dr, other)	
Name:	
Date of Birth	
Sex assigned at birth: <i>We ask for your assigned sex to help us screen for sex- specific diseases such as cervical/prostate cancer</i>	Male Female Prefer not to say
Do you identify with a different gender to your birth gender? Pronouns:	Yes / No <i>Eg. She/her, They/them, He/Him</i>

Ethnicity

Asian British	Mixed White & Asian	Other :
Black African	Mixed white & Black African	Prefer Not to Say
Black British	Mixed white & Black Caribbean	White Other
Black Caribbean	Other Asian Background	White British

Height		
Weight		
<p>Family History:</p> <p>Do you have any illnesses in your family?</p> <p><i>Such as cancer, heart disease, diabetes, ect.</i></p> <p>Please include family member & health condition</p>		
<p>Allergies/side effects:</p> <p><i>(Such as allergic reactions to medications, bee stings, foods, etc..)</i></p>		
<p>Do you have, or have you had, any serious health problems (including operations) or long term conditions?</p> <p><i>If YES please include details & dates:</i></p>	Yes/No	
<p>Do you consider yourself to have a disability:</p> <p><i>If YES please give brief details</i></p>	Yes/ No/ Prefer not to say	
<p>Smoking status:</p> <p><i>If YES, how many per day:</i></p> <p><i>If EX SMOKER, when did you quit:</i></p>	<p>Yes / No / Ex-smoker</p> <p>(We offer Smoking Cessation appointments with our nurses)</p>	

Are you being prescribed medication?	<input type="checkbox"/> YES <input type="checkbox"/> NO , Please skip this page
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Medication For example: Aspirin	Dose For Example: 75mg once daily	Reason for medication For Example: "I had a stroke"

Which pharmacy would you like your prescriptions sent to:	
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Please book a face to face appointment with your new doctor before you ask for any prescriptions or medications.

**If you are going to run out of medication,
ask your previous GP surgery for a prescription.**

Please note we prescribe according to national guidelines.

Painkillers including Gabapentin and Pregabalin

We do not prescribe opiates or gabapentinoids for long term pain. This includes codeine, tramadol, zopain, dihydro-codeine, gabapentin and pregabalin. If you are taking these drugs for long term pain, we will prescribe a reducing course of these drugs and stop them.

Sleeping tablets.

We do not prescribe long term benzodiazepines for sleep problems.

This includes zopiclone, zolpidem and temazepam.

If you are taking these drugs, we will prescribe a reducing course of these drugs and stop them.

Benzodiazepines

We do not prescribe long term benzodiazepines. This includes diazepam. If you are taking these drugs, we will prescribe a reducing course of these drugs and stop them.

Please sign here to say you have read and understood this page

Signature _____ Name _____ Date _____

<p>Summary Care Record</p> <p>A Summary Care Record is used in Emergency Care. It contains information about your medicines, allergies & bad reactions to drugs to ensure your carers have enough information to treat you safely.</p>	<p>Your Summary Care Record will be available to Authorised staff providing your care in England & will ask permission to look at it.</p> <p>Should there be an accident or illness Healthcare Staff will have immediate access to important information about your health.</p> <p>A Summary Care Record will automatically be created for you unless you wish to opt out.</p> <p><i>If you do wish to opt out, please indicate here:</i></p> <p style="text-align: center;">Opt OUT</p> <p style="text-align: center;"><input type="checkbox"/></p>
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Emergency Contact details <i>(someone we can contact if medically necessary)</i>
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Relationship status: <i>e.g. Mother, Father, Spouse, friend, flat mate,...</i>	
Title And Full Name: <i>(Mr, Miss, Mrs, Ms, Mx, Dr, other)</i>	
Address:	
Mobile Number:	
Home Telephone Number:	
Are they registered as a patient at Pavilion Surgery?	Yes / No

Emergency Contact details <i>(someone we can contact if medically necessary)</i>
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