Adult Registration Form
PLEASE COMPLETE THIS FORM IN FULL USING BLOCK CAPITALS

To register we require two forms of ID:
- **Photo Identification – passport or driving license**
- **Proof of Address – i.e. bank statement, council tax letter or utility bill.**

Have you ever been registered at this practice before?   Yes ☐   No ☐

General Information	
Full Name	
Date of Birth	
My height	
My weight	
Marital Status	
Armed Forces	*Have you ever served in the British Armed Forces? Yes* ☐ *No* ☐

Contact Details	
Mobile Number	
Home Number	

***I consent to receiving SMS text messages from Scott Road Medical Centre regarding appointment reminders and relevant health invitations. (Please tick) Consent* ☐ *Dissent* ☐**

Email	
Email address	

We occasionally use your email address to communicate with you about your direct medical care.

We may also email you other useful information unrelated to your direct medical care - for example surgery newsletters, surgery information, staff changes and minutes from patient participation meetings.

☐ **Please tick here if you consent to Scott Road Medical Centre contacting you by email with Non-medical information**

We never pass your email onto any third parties (unless you have given us your consent to do so) you can withdraw consent at any time by informing Reception.

Do you have repeat medication? If yes, please provide us with a copy of your repeat medication list from your previous GP

Nominate a Pharmacy We now send all prescriptions electronically to your preferred pharmacy, please nominate a pharmacy.	**Pharmacy Name & Location**

If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer Contact Details:**
If you are a Carer, please state your name/address/phone number of the person who you care for:	**Person Cared for Contact Details:**

Specific Needs*: *This is to enable us to accommodate your needs. Please specify any specific requirements you may need below.

Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):	
Are you an Assistant Dog User?	
Please state any Physical/ Mental disabilities you have?	
Do you have any access requirements?	
Do you have any phobias?	

Do you suffer from allergies or sensitivities?
If Yes, please provide details

Family History - Please tick ANY box that applies to you		***Please state who?***
A member of my family suffers from **Diabetes** E.g., Father, Mother, Brother, Sister	☐	
A member of my family suffers from **Hypertension** e.g., Father, Mother, Brother, Sister	☐	
A member of my family suffers from **heart disease** that started BEFORE they were 60 years of age e.g., Father, Mother, Brother, Sister	☐	
A member of my family suffers from **Asthma** e.g., Father, Mother, Brother, Sister	☐	

Employment status - Please tick the box that applies to you	
I am employed full time ☐	**I am unemployed** ☐
I am employed part time ☐	**I am retired** ☐
I am self employed ☐	**I am medically retired** ☐
I am a student ☐	

Ethnicity – Please tick only 1 box			
White	British	☐	XaJQv
	Irish	☐	XaJQw
	Any other white background	☐	XaJQx
Mixed	White & Black Caribbean	☐	XaJQy
	White & Black African	☐	XaJQz
	White & Asian	☐	XaJR0
	Any other mixed background	☐	XaJR1
Asian or British Asian	Indian	☐	XaJR2
	Pakistani	☐	XaJR3
	Bangladeshi	☐	XaJR4
	Any other Asian background	☐	XaJR5
Black or Black British	Caribbean	☐	XaJR6
	African	☐	XaJR5
	Any other background	☐	XaJR8
Any Other Ethnic Background	Chinese	☐	XaJR9
	Any other (please describe)		XaJRA
Please state your first language			

Smoking status – Please tick only 1 box		
I am a smoker	☐	**If you are a smoker and would like help in trying to stop smoking, please contact North Yorkshire Living well smoke free on 01609 797272**
I am an ex-smoker	☐	
I have never smoked	☐	
I am not willing to disclose	☐	
I smoke E-Cigarettes	☐	

Alcohol screening (over 16's only) 1 unit = ½ pint of beer or 1 single shot of spirits. 1 small glass of wine = 1.5 units (136)
Number of units you drink per week =

We are required by the Integrated Care Body (ICB) to ask all new patients aged 16 and over how much and how often you drink alcohol?

Please help us help you by completing this quick survey.

For each question tick the answer that applies to you.

If your answer to the first question is 'Never' there is no need to complete this questionnaire.

Part 1

Score	0	1	2	3	4	
How often do you have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	**Your score**
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 8	10+	**Your score**
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	**Your score**

Part 2a – Please only complete Part 2a & Part 2b if you scored 5 or more in Part 1

Score	0	1	2	3	4	
How often in the last year have you found you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	**Your score**
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	**Your score**
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	**Your score**
How often in the last year have you had a feeling of guilt or regret after drinking	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	**Your score**
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	**Your score**
				Your score for Part 2a		

Score	0		2		4	
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	**Your score**
Has a relative/friend/ Health Worker ever been concerned about your drinking and advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	**Your score**
				Your score for Part 2b		

Your score from Part 1	
Your score from Part 2a & b	
Your total score	

Patient Participation Group

The Practice is committed to improving the services we provide to our patients. To do this it is vital that we hear from people about their experiences, views and ideas for improving services. By expressing your interest, you will be helping us to plan ways of involving patients that suit you. It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.	
Yes, I am interested in becoming involved in the Patient Participation Group and would like to be contacted by a representative from the group (please tick)	
You can opt out at any time, please contact us here at the surgery. This will not affect any other care we provide for you.	

Summary Care Record (SCR)

The objective of a Summary Care Record is to share key information from your GP records. This enables other NHS services such as A&E or Out of Hours to access your essential health information as and when required. This is particularly beneficial to you in an unplanned or emergency situation.

There are two types of Summary Care Records that can be created:

a) 'Standard Core' Summary Care Record
This includes sharing your current and repeat medications, any allergies you suffer from and any harmful reactions to medication you have experienced.

b) 'Enhanced Core' Summary Care Record
This includes sharing your 'standard core' records with additional medical information that includes: Your significant illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

We will automatically opt-in all patients to share their Enhanced Core Summary Care Record (option b) unless you choose otherwise. You are free to change your decision at any time.

Having read the above information regarding my choices I would not like a Summary Care Record (opt-out)

☐ Express dissent for Summary Care Record

I can confirm that I have read and understood all the details in this document and that the information I have supplied is up to date and accurate.

Signature of Patient ☐ Date:

Or

Signature on behalf of patient: ☐ Date:

For office use only:-

For registrations

Photo ID: - ☐ Driving License ☐ Passport

☐ Verified by ______________ on ___________

☐ Proof of address verified by ____________ on ____________

Patient unable to provide: - ☐ Photo ID ☐ Proof of address