THE SURGERY

Dr Zaw Thike MBBS DFFP MRCGP DRCOG
Dr Julie Marshall MBCHB DFFP DRCOG

PRIVATE AND CONFIDENTIAL

NEW PATIENT REGISTRATION QUESTIONNAIRE

To be completed by all new patients aged 16 and over

THE SURGERY
CHURCH ROAD
LYMINGE
FOLKESTONE
CT18 8HY
Telephone: 01303 862109
Fax: 01303 863643

Email: kmccg.lymingesurgery@nhs.net

A very warm welcome to our small rural dispensing Surgery which accepts patients from Lyminge, Hawkinge, Elham, Stelling Minnis, Rhodes Minnis, Ottinge, Postling, Newington and other local surrounding Villages.

Please kindly complete all 3 pages of this questionnaire along with a fully completed GMS1 registration form so we can input your information onto our clinical system.

Please book an appointment with one of our nurses for your New Patient Check.

Please refer to the surgery booklet in relation to information within the questionnaire as well as other relevant information you may find useful.

Your Allocated Named GP is Dr Zaw Thike

Should you require any further information or assistance then please do not hesitate in speaking to a member of the reception team or the Practice Manager

PLEASE BRING BACK TO THE SURGERY – DO NOT POST

Reception Staff Only – Please initial to confirm completed

Emis Number	

Consent		Family/Relationship Link	
Communication and/or information needs		Ethnicity	
New Patient Check booked		New Patient Template completed	

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Personal Information

Title:	**Forename:**	**Surname:**	**Date of Birth:**

Address: **Postcode:**

Home Telephone Number:	**Mobile Number:**
Email Address:	

Please note: ALL CONTACT DETAILS WILL BE SHARED AND COULD BE USED FOR DIRECT PATIENT CARE

Ethnicity				
First Language		**Translator required**	**YES**	NO

Communication needs **Do you have any communication/information needs relating to a disability, impairment or sensory loss and if so what are they** (please give details)**:**	**YES**	**NO**

Do you have any allergies? If yes please state what they are:	**YES**	**NO**

Consent

Messages I give consent for the practice to leave messages on my answerphone	**YES**	**NO**
Messages with 3rd Party I give consent for the practice to leave a message with the persons named below about any aspect of my medical treatment	**YES**	**NO**
Names: _____		
Medical Details I give consent for the practice to disclose results and to discuss any medical treatment or problems with the persons named below:	**YES**	**NO**
Names: _____		
Any consent given will remain in force until further notice or cancellation by me **Patient signature:** **Date:**		

STAFF ONLY – Added to Emis System	**Name:**	**Date:**

Your Prescriptions – If you live more than 1 mile from a Pharmacy we are able to dispense your medication to you from the surgery – if you live under 1 mile we will send your prescriptions electronically to the Pharmacy of your choice
Which Pharmacy would you like your prescriptions sending to?

Your Health Records

Your health records contain confidential patient information, which can be used to help with research and planning. If you would like this to stop, you can opt out of this yourself or on behalf of someone else. For example, if you are a parent or guardian of a child under the age of 13. Your confidential patient information will still be used for your individual care. Any choice you make will not change this.

For further information or to opt out please go to www.nhs.uk/your-nhs-data-matters

Carers
A carer is someone who looks after a relative or friend who needs support because of age, physical or learning disabilities or illness.
Parent carer - a parent of a disabled child often see themselves as parents rather than carers, however additional services and support may be available
Young carers – This means carers who are under 18. The person receiving care is often a parent, but it could be a brother, sister, grandparent or another relative who needs support.

If you are a carer and would like your name to be added to our register of carers, then please ask at reception for a carer form.

Are you a carer?	**Yes**	**No**
Does someone care for you?	**Yes**	**No**

Patient Participation Group

Would you like to receive information about our patient participation group via email?	**YES**	**NO**

Next of Kin

Mr/Mrs/Miss/Dr etc_____

Full Name_____

Contact Number _____

Relationship to patient_____

Is this your emergency contact? YES / NO

New patient questionnaire – 3 page document read and completed

Patient Signature	**Date Completed**

Thank you for your time in completing this questionnaire which will help us until we receive your medical records from your previous GP.