New Patient Registration
Adult

We would like to take this opportunity to welcome you to Lightwater Surgery.

Please ensure you have also received a copy of our Practice Information Booklet which gives details of the services we offer. You can also find more information on our website: www.lightwatersurgery.co.uk

Please let one of the receptionists know if you would like to register for EMIS Access which allows patients to book routine appointments, request repeat prescriptions and view parts of your medical record online.

You can also download the NHS App; a simple and secure way to access a range of NHS services on your smartphone or tablet. More information on the NHS App can be found online (https://www.nhs.uk/using-the-nhs/nhs-services/the-nhs-app/) or by scanning this QR code:

It can take several weeks for your medical records to reach us and we would be grateful if you could complete the enclosed brief questionnaire, (one for each family member). This will provide us with some essential information before your medical records arrive with us.

We encourage new patients to attend for a free health check with one of our Practice Sisters or our Health Care Assistant. The check lasts around 15 minutes and will include measurements of your height, weight and blood pressure, together with a urine test. These tests can provide important information and can be a useful introduction to the practice.

If you are registering any **children aged 0-16**, please could you kindly complete the Young Person Aged 0-16 registration form.

If you have any children **under the age of 5**, please could you kindly complete one of our Health Visitors questionnaires. They can then make contact with you to ensure that the necessary checks and vaccinations can be arranged.

Chk	Reg	Smo	Alc	Car	Dia	SCR	Don

Lightwater Surgery

Title	First Name	Surname	Date of Birth
Known Allergies		Current Medication *If you are on any medication, please make an appointment with a GP for this to be prescribed*	
Family History: Has any first degree relative (parent, brother, sister) ever had the following:			
Heart Attack or Angina	YES / NO	Stroke	YES / NO
Personal Medical History: Do you have a history of any of the following:			
High Blood pressure	YES / NO	Diabetes	YES / NO
Stroke	YES / NO	Asthma	YES / NO
Heart Attack	YES / NO	COPD	YES / NO
Angina	YES / NO		
Any other significant Illnesses:		Any operations or Hospital treatment:	

Are you a person being cared for?	YES / NO	If YES, please provide your Carer's details Full Name: Contact Number:
Do you consider yourself a Carer?	YES / NO	If YES, please provide details of who you care for Full Name: Relationship to you:

Women Aged 25 – 64	Have you had a cervical smear test?	YES / NO
If YES, what was the approximate date of that test?		
If you have had a hysterectomy, please give the approximate date of the operation		

Smoking History		
	Please state type of tobacco used (eg cigarette, e-cig, cigar)	Please state amount smoked per day
Current Smoker		
Ex-smoker		
Never Smoked		

Ethnic Group					
White	British		Asian or Asian British	Indian	
	Irish			Pakistani	
	Other White Background			Bangladeshi	
Mixed	White and Black Caribbean			Other Asian Background	
	White and Black African		Black or Black British	Caribbean	
	White and Asian			African	
	Other Mixed background			Other Black Background	
Not Stated					

Alcohol					
How often do you have a drink containing alcohol?					
Never	Monthly or less	2 -4 times per month	2 -3 times per week	4+ times per week	
Please indicate the number of units of alcohol you drink each week: *1unit = ½ pint beer at 3.6% Or 83.3mls of wine at 12% Or 1 small shot of spirits (25ml of 40%)*					
0-5	6-10	11-15	16-21	22-30	>30

Please answer the following questions:

	Never	Less than monthly	Monthly	Weekly	Daily or Almost Daily
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?					
How often during the last year have you found that you were not able to stop drinking once you had started?					
How often during the last year have you failed to do what was normally expected from you because of your drinking?					
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?					
How often during the last year have you had a feeling of guilt or remorse after drinking?					
How often during the last year have you been unable to remember what happened the night before because you had been drinking?					

DATA SHARING OPTIONS

Please complete in BLOCK CAPITALS
If you are filling out this form on behalf of a child, please ensure you fill out their details here:

Title:	Surname:
Forenames:	
Address:	
Postcode:	Phone Number:
Date of Birth:	Signature:

Your details (if different from above)

Your name:	Your signature:
Relationship to patient:	

Summary Care Records (SCRs) enable healthcare professionals working in different care settings to access an electronic summary of key information from a patient's GP record. Currently, SCRs are widely used across NHS urgent and emergency care, such as NHS 111, 999 and Accident & Emergency Departments. However, the SCR may also be used in planned care to provide up to date clinical information.

If you choose to have a Summary Care Record, it will automatically contain important information about any medicines you are taking, any allergies you suffer from and any bad reactions to medicines that you have previously experienced.

You can also choose to add '**enhanced** information' to your Summary Care Record. This will include significant medical history and details about immunisations, your information and / or communication needs and your personal preferences.

Please tick to indicate your Summary Care Record choice:

Patient Consents to sharing the detailed record	
Patient Consents to sharing an **enhanced** record	
Patient DOES NOT wish to share the detailed record	
If you are a Diabetic: Do you consent to Lightwater Surgery sharing your details with the National Diabetes Audit?	Yes / No

Lightwater Surgery would like to be able to contact you, via email and text message, for screening invitations, appointment reminders, letters etc. If you consent to this, please add your personal email address and mobile number here.

Email address:
Mobile phone number:

Signed: ……. Date: ……