MESSAGE CONSENT: In accordance with GDPR the Practice needs consent from all patients to allow us to communicate with you via sms/email, leave messages on your voicemail and with a relative/carer.

☐ **I DO** give consent for the practice to communicate with me via sms/email and also leave messages on my voicemail.

☐ **I DO NOT** give consent.

☐ **I DO** give consent for the Practice to leave a message about any aspect of my medical treatment with ……..

PRESCRIPTION COLLECTION BY 3RD PARTY : With effect from 21 April 2008, any patient wishing for someone else to collect their prescription will have to give the Practice signed consent. Reception staff will not be able to hand a prescription over to anyone collecting on someone's behalf without prior consent.

☐ **I give consent** for ……..to collect prescriptions on my behalf.

☐ **I do not give consent** for any 3rd party to collect prescriptions on my behalf.

☐ **Not applicable.**

This consent is to remain in force until further notice of cancellation by me.

SUMMARY CARE RECORDS: (If you do not tick a box it will automatically happen)

The NHS England is introducing the Summary Care Record, which will be used in emergency care. The record will contain information about any medications you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information.

Your GP practice is supporting Summary Care Records and as a patient you have a choice:

☐ **YES I would like my summary care record** - you do not need to do anything and a Summary Care Record will be created for you.

☐ **NO I do not want a Summary Care Record** -Please ask a member of reception for a form to fill in.

You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP Practice.

SHARING DATA IN & OUT: (If you do not tick a box it will automatically happen)

Do you consent to the sharing of data recorded here with any other organisations i.e. physiotherapy that may care for you? ☐ **YES** ☐ **NO**

Do you consent to the viewing of data by this organisation that is recorded at other care services i.e. physiotherapy that may care for you where you have agreed to make the data shareable? ☐ **YES** ☐ **NO**

Signed ……..

Print Name ……..

Date ……

For staff use only:
Correctly filled in Y/N
ID Checked Y/N
Address in area Y/N
Received By :

CRANESWATER GROUP PRACTICE

NEW PATIENT REGISTRATION FORM

Title (Mr, Mrs, Miss, Ms)			
Surname			
Forenames			
Previous Names			
Date of Birth			
NHS Number			
Male/Female			
Address			
Postcode			
Place of Birth			
Telephone Number(s)			
Email Address			
Marital Status			
Your Occupation			
Are you a military Veteran?	YES / NO	**Are you a carer?**	YES / NO
Previous Surgery Address & Doctor			
Next of Kin Name			
Relationship to you			
Next of Kin Telephone Number(s)			
Is your next of kin registered at this practice?	YES / NO		

ETHNIC ORIGIN :

African		Other Black Background	
Bangladeshi		Other Mixed Background	
British OR Mixed British		Other White Background	
Caribbean		Pakistani	
Chinese		White & Asian	
Irish		White & Black African	
Indian		White & Black Caribbean	
Other Asian Background		I Do Not Wish To Give My Ethnic Origin	

Religion	

First/Main Language Spoken?			
Do you need an Interpreter?	YES / NO		
Are you from abroad?	YES / NO	Date you first came to live in the UK	

ABOUT YOU:

Height		Weight	
Do You Smoke?	YES / NO	Have You Ever Smoked?	YES / NO
What Date/Year Did You Give Up Smoking?		Would You Like Any Information Regarding Quitting?	YES / NO
How often do you have a drink containing alcohol?	☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week		
How many standard drinks containing alcohol do you have on a typical day?	☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 or 9 ☐ 10 or more		
How often do you have six or more drinks on one occasion?	☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily		

FAMILY HISTORY :

CONDITION	YOU	OTHER FAMILY MEMBER & RELATIONSHIP TO YOU
Stroke		
Raised Blood Pressure		
Heart Disease		
Diabetes		
Asthma/ Respiratory Problems		
Mental Health Problem		
Thyroid Problem		
Epilepsy		
Cancer (please state, e.g. Bowel etc)		

YOUR MEDICAL HISTORY :

PAST MEDICAL HISTORY (Operations etc)

ALLERGIES

ARE YOU ON ANY REPEAT MEDICATION? (Please include HRT OR Contraceptive Pill)
-Please note, you will need to see a Doctor before you can be issued with a repeat prescription

Would you like your prescriptions to go electronically to a pharmacy? **YES / NO**

If yes, Please specify the pharmacy & its address :

For Female Patients Only!

Approximate date of last Cervical Smear : ……

Result : ……