PARKLANDS SURGERY
New Patient Registration Form

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in **BLOCK CAPITALS** and tick the boxes as appropriate.

Please provide proof of identity and address.

If you have never been registered with a GP in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

First Name	**Surname**			**Telephone Number**
Mr / Mrs / Miss / Ms / Other……..				**Work Number**
Address and Postcode				**Mobile Number**
				E-mail Address
				Next of Kin
				Next of Kin Contact Number
Date of Birth	**Gender**	**Male**	**Female**	**Town & Country of Birth**
Previous / Mother's surname if different to above:				**NHS Number (if known)**
Previous Address & Postcode:				**If applicable, date you first came to live in Britain?**
Previous Doctor Name & Full Address				**If returning from Armed Forces, your Service or Personnel Number:** **Your Leaving Date** **Your Enlistment Date**

Your Ethnic Origin (select one)	**White (UK)**	**White (Irish)**	**White (Other)**
Caribbean	**African**	**Asian**	**Other Mixed Background**
Indian / Brit Indian	**Pakistani / Brit Pakistani**	**Bangladeshi / Brit Bangladeshi**	**Other Asian Background**
Other Black Background	**Chinese**	**Other**	**Not Stated**

Your main or 1st language spoken / understood (select one)	**English**	**French**	**German**	**Polish**	**Hindi**	**Punjabi**
	Spanish	**Ukrainian**	**Bengali**	**Urdu**	**Other (please specify)**	

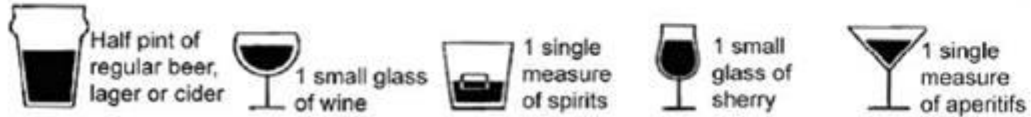
Your Religion	**Church of England**	**Catholic**	**Other Christian**	**Buddhist**	**Sikh**	**Other (please state)**
	Jewish	**Jehovah's Witness**	**Muslim**	**Hindu**	**No Religion**	

Smoking:							
Are you currently a smoker?	YES	NO	Have you ever been a smoker?	YES	NO	How many cigarettes/ cigars/tobacco do you smoke per day?	Quantity:

Your Height	Feet / Inches	cm	Your Weight	Stones / lbs.	Kg.

Would like information regarding Quit Smoking?	Yes	No

This is one unit of alcohol…



…and each of these more than one unit of alcohol

Questions:	Scoring system					Your Score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

A total of 5+ indicates increased or higher risk drinking. If you scored 5 or more consider making an appointment to discuss this with the nurse. Would you like an appointment to see a nurse?	Yes	No	Total Score =	

Summary Care Records

The NHS is changing the way your health information is stored and managed.
The NHS Summary Care record is an electronic record of important information about your medication and allergies.
Should you require medical treatment anywhere else in the UK your records will be available to the medical team to ensure you receive the best possible care.

Are you happy to have a Summary Care Record?	Yes	No	PLEASE SIGN TO CONFIRM

Patient Signature:		Signature on behalf of Patient:	
Today's Date:		ID Checked (Staff Use Only)	

<table>
<tr><th colspan="4">Specific Needs:
Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:</th></tr>
<tr><td>Please state any Sensory Impairment you have
(i.e. Speech, Hearing, Sight)</td><td colspan="3"></td></tr>
<tr><td>Are you an ‘Assistance Dog’ User?</td><td colspan="3"></td></tr>
<tr><td>Please state any Physical disabilities you have.</td><td colspan="3"></td></tr>
<tr><td>Please state any Mental disabilities you have.</td><td colspan="3"></td></tr>
<tr><td>Do you require the help of a Translator / Interpreter?</td><td colspan="3"></td></tr>
<tr><td>Please state any allergies and sensitivities you have.</td><td colspan="3"></td></tr>
<tr><td>Have you ever had a social worker involved with your family?</td><td colspan="3"></td></tr>
<tr><td>If you are a Carer, please state the name / address / phone number of the person you care for.</td><td colspan="3"><u>Person Cared For Contact Details:</u></td></tr>
<tr><td rowspan="2">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.</td><td colspan="3"><u>Carer Contact Details:</u></td></tr>
<tr><td colspan="3"><u>Signed:</u> <u>Date:</u></td></tr>
<tr><td>Do you have a “Living Will”
(a statement explaining what medical treatment you would not want in the future)?</td><td>Yes</td><td>No</td><td>If “Yes”,
please bring a written copy
to your New Patient Consultation</td></tr>
</table>

<u>Patient Participation Group</u>

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 our services. If you are interested in taking part, please contact the surgery.

As a new patient to the practice we would like you to make an appointment for a new patient health check with one of our Nurses.
The appointment is important, as it will enable us to ensure we have your full medical history available to us.
Please telephone the surgery on 01933 396000 and make an appointment.
If you are on repeat medication please make an appointment to see a Doctor prior to your prescription running out.

For more information about the services we offer, please see our website
www.parklandssurgery.co.uk

TEXT AND/OR EMAIL COMMUNICATION CONSENT FORM

Declaration

I consent to the Practice contacting me by text message and/or email for the purposes of health advice and appointment reminders. The Practice will not share your mobile telephone number and/or email address with any third party.

I understand the SMS service should not be solely relied upon, as the responsibility for attending and cancelling appointments rests with me.

Text messages are generated using a secure facility, but I understand that they are transmitted over a public network on to a personal telephone.

I will keep the Practice informed of my up to date mobile number and/or email address at all times. I will also inform the Practice if the number and or/email address is no longer in my possession.

If more than one person shares the use of the mobile phone and/or email address detailed below, we will need a consent form from each of those people.

Patient Name:	
Date of Birth:	
Mobile Telephone Number:	
Email Address:	
Signature:	
Today's Date:	

PLEASE NOTE

The Practice will NOT send out any text messages and/or emails unless you have explicitly consented by completing this form.