

REGISTERING WITH THIS PRACTICE

Please complete this form as fully as possible. As part of your application we will offer you an appointment for a new patient health check which will only take a short time.

Note – this practice does not prescribe Temazepam, Diazepam or Dihydrocodeine unless there is a documented medical need for it.

All surgeries are run on an appointment basis; if you cannot attend please cancel your appointment. If you arrive late for an appointment you will only be seen if the doctor agrees to it.

Please complete the following form as completely as possible noting that all applicants must provide evidence of residency at their current address. A utility bill will suffice.

If you have come to this country from abroad and are requesting to register with a doctor, it is necessary for you to provide us with photocopies of your paperwork confirming your entitlement to remain in this country for more than 6 months (original documents must also be available for us to view) documents can be photocopied by the Practice.

Examples of suitable document are:-

- A current British or European Community Passport.
- A work permit
- A valid visa (with more than 6 months left to run)
- Home office paperwork for asylum seekers or refugees.
- If you are a student, a letter from your college/university confirming the duration of your studies.

If you have any medical/vaccination records please bring these with you to the surgery.

We do not accept requests for repeat prescriptions over the telephone.

A copy of the practice booklet is available on our web site at www.woodsendmedicalcentre.nhs.uk



Woodsend Medical Centre New Patient Registration Form

<u>Today's Date:</u>

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.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Please complete a separate form for each family member to be registered.

Full Name:					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:		Previous / Mother's surname if different:			Town & Country of Birth		
Marital Status:		Gender:	Male:	Female:	Other residents of your home:		
Occupation:							
Names & Ages of Children							
Housing (Select one)	House	Maisonette	Flat	Mobile Home	NHS Number (If Known)		
Previous Address					Previous Postcode:		
					Previous Doctor Telephone No.		
Previous Doctor Name & Address:					Previous data released?	Yes	No
					If applicable, date you		

Partners - Dr A Khalid, Dr C Appleton, Dr M Rajkumar, Dr M Ruparelia,
 Salaried Doctors - Dr R Kumar, Dr E Winters, Dr N Spencer, Dr F Shamim
 Nurse Practitioner – Yvonne Sinclair
 Management - Nicki Price, Managing Partner and Mandy Black, Practice Manager



					first came to live in Britain:	
If returning from Armed Forces:		Your Service or Personnel Number			Your Enlistment Date	
Your height:	Feet / inches	cm	Your weight:	Stones / lbs.	kg	
Your Religion:	C of E	Catholic	Other Christian (state)	Buddhist	Hindu	Muslim
	Sikh	Jewish	Jehovah's Witness	No religion	Other religion (state)	
Your Ethnic Origin: (select one)		White (UK) 9i0	White (Irish) 9i1%	White (Other) 9i2%		
Caribbean 9i3		African 9i4	Asian 9i5	Other Mixed Background 9i6%		
Indian / Brit Indian 9i7		Pakistani / Brit Pakistani 9i8	Bangladeshi / Brit Bangladeshi 9i9	Other Asian Background 9iA%		
Other Black Background		Chinese 9iE	Other 9iF%	Ethnic Category not stated 9iG		
Your main or 1 st language Spoken / Understood: (select one)		English	Hindi	Gujurati	Urdu	Bengali /Sytheti
Polish	Ukrainian	French	German	Spanish	Other: (Please Specify)	
Smoking, Alcohol Consumption and Exercise:						
Are you currently a smoker?		Yes	No	Have you ever been a smoker?		Yes
If so, how many cigarettes / cigars / tobacco do you smoke in a week?				How much alcohol do you drink in a week (Units)? (One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)		No
If you are a smoker and want to stop, please ask for information about local smoking cessation services.						

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How often do you exercise?	No. times per week	Type(s) of exercise:	
Your Medical Background:			
What illnesses have you had & When?			
What operations have you had and When?			
Do you have any medical problems at present?			
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)			
Are you able to administer your own medicines?	Yes	No – please detail specific issues (e.g. swallowing, opening containers)	



Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)	Diabetes	Heart Attack	Heart attack under age of 60	Bowel Cancer	
	Breast Cancer		High Blood Pressure	Asthma	Stroke
	Thyroid Disorder		Any other important Family Illness?		

What immunisations have you had? (please tick all that apply)	Diphtheria	Measles	German Measles	Tetanus	Polio	MMR
	Whooping Cough		Pre-school booster	Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses		

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:

Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):	
Are you an 'Assistance Dog' User?	
Please state any Physical disabilities you have:	
Please state any Mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises	
Please state any Religious or Cultural needs:	
Do you require the help of a Translator / Interpreter?	
Please state any specific nutritional requirements you have:	
Please state any allergies and sensitivities you have:	
Please state any phobias you have:	

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If you look after someone, please state the name / address / phone number of the person you care for:	<u>Person Cared For Contact Details:</u>			
If you are looked after, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	<u>Carer Contact Details:</u>			
	<u>Date:</u>		<u>Signed:</u>	
Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	Yes / No	<i>If "Yes", can you please bring a written copy of it to your New Patient Consultation</i>		
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	Yes / No	If "Yes", please state their name / address / phone number:		
Women only:				
When was your last smear done?	Date	Was this at your GP's Surgery?	Yes	NO
What was the result of the smear?				
Date of last mammogram (if applicable):	Date	Method of contraception (if used):		
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?			Yes	NO
<u>Summary Care Records.</u>				
<p>The NHS are changing the way your health information is stored and managed. The NHS Summary Care record is an electronic record of important information about your health. It will be available to health care staff providing your NHS Care. An information pack has been provided.</p>				

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Are you happy to have a Summary Care Record?	Yes	No	More Time Required to decide:
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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 making services better.

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.

If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.

Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box)	Yes
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Patient Signature:		Signature on behalf of Patient:	
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Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).

The Consultation will also establish relevant past medical and family history, including:

- *Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health*
- *Social factors - employment, housing, family circumstances*
- *Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.*

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or see our website: www.woodsendmedicalcentre.nhs.uk

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Woodsend Medical Centre New Family Questionnaire

Welcome to Woodsend Medical Centre. At Woodsend we are working to improve the care and safeguarding of all children and in order to do this we need to ask all new families registering with us some questions.

Please complete the following questions and return them with your registration forms.

Do you have any children under 18 living with you? (Please circle)

Yes

No

If yes please give ages,

.....
.....
.....

Have any children living with you ever been

Looked after or fostered?

Yes

No

Had a social worker or any support?

Yes

No

Had any safeguarding or child protection issues

Yes

No