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New Patient Registration – Additional Information

About you

Surname: …………………………………… Forename(s): ……………………………………….

Date of Birth (dd/mm/yyyy): ………………. NHS number (if known): …………………………

Gender: …………………………………… (www.nhs.uk/find-nhs-number)

Contact Information

Address:…………………………………………………………………………………………..…….

Telephone: ……………………………………. Mobile: ………………………………………………

Email: ………………………………………………………………………………………………….

Do you live in a residential home? **Yes** ☐ **No** ☐

Do you live in a nursing home? **Yes** ☐ **No** ☐

Would you describe yourself as homeless? **Yes** ☐ **No** ☐

What is your occupation?...

Disabilities

Are you registered blind or partially sighted **Yes** ☐ **No** ☐

Do you have hearing difficulties **Yes** ☐ **No** ☐ **Deaf** ☐

Please record any other disability: ……………………………………………………………..……

……………………………………………………………………………………………………….

Gender and Sexuality

How would you like us to talk about you?

Preferred title: ………………………………………………………………………….…………

Preferred name and title on correspondence: ……………………………………………..

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Contacting you

Please indicate our preferred choice of contact:

Text ☐ **Phone** ☐ **Email** ☐ **Post** ☐

We will use your contact details to send reminders about appointments, reviews and other services which may be of benefit in your medical care

Do you consent to the Surgery sending letters to your home address? **Yes** ☐ **No** ☐

Do you consent to the Surgery sending text messages to your mobile? **Yes** ☐ **No** ☐

Do you consent to the Surgery sending messages to you by email? **Yes** ☐ **No** ☐

Do you consent to the Surgery leaving messages on your phone? **Yes** ☐ **No** ☐

(We will not leave detailed messages on your phone, but may ask you to contact us or leave a simple message if we do not need to speak to you).

Are you interested in joining our Patient Participation Group (PPG)? **Yes** ☐ **No** ☐

Local Shared Electronic Health Record

Many areas of the country have a local shared electronic health record too. Giving healthcare staff access to this information can prevent mistakes being made when caring for you in an emergency or when your GP practice is closed. Are you happy for your record to be shared across organisations caring for you? (this is accessed by relevant staff for your direct care on a need-to-know basis only)

Are you happy to be part of the local shared electronic health care record?
(if you select no, you need to be aware that NHS Healthcare staff may not be able to see important elements of your care history) **Yes** ☐ **No** ☐

General Practice Data for Planning and Research Data Sharing Dissent

Do you wish to opt out of the General Practice Data for Planning and Research **Yes** ☐ **No** ☐

(Opt out of sharing your health records - NHS (www.nhs.uk)_

Donation wishes

If you live in England, Wales or Jersey, are not in a group excluded from opt out legislation and you have not registered an organ donation decision, it will be considered that you agree to be an organ donor. This is known as deemed consent.
If you do not want to donate your organs then you should register your decision to refuse to donate. Remember to speak to your family and loved ones about your decision. To opt out, visit:
Do not donate - NHS Organ Donation

Do you donate blood? **Yes** ☐ **No** ☐

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Resuscitation wishes and Power of Attorney

Do you have a DNACPR (Do not attempt CPR) form in place? **Yes** ☐ **No** ☐

Does anybody hold Lasting Power of Attorney for Health and Welfare for you? **Yes** ☐ **No** ☐

If **YES to either of the above questions**, please supply details of who holds this and where (and supply a copy for your medical notes).

Details……………………………………………………………………………………………………
……..

Family History and past medical history

Have any close relatives (parent, sibling or child only) ever suffered from any of the following?

Condition	Yes	No
Heart Disease (Heart attack/Angina)		
Stroke		
Diabetes		
Asthma		
Cancer		

Have you yourself ever suffered from any important medical illness, operation or admission to hospital? **If so** please enter details below:

Condition	Year diagnosed	Ongoing?

Female patients only

Are you currently pregnant? **Yes** ☐ **No** ☐

If yes, *please ensure you are under the care of a midwife. If you're not currently under the care of a midwife please speak to reception regarding this.*

Which method of contraception (if any) are you using at present?

……..

Do you currently have long acting reversible contraception in place? *(Implant/Coil)*

Yes ☐ **No** ☐

If yes, when was this fitted? (dd/mm/yy) ……………………………………

Have you had a cervical smear test? **Yes** ☐ **No** ☐

If yes, when was this last done? (dd/mm/yy) ……………………………………