**For surgery use only**

Emis Number:………………………… Checked by (initials)………..

SELDEN MEDICAL CENTRE

**New Patient Registration Form**

* **IMPORTANT**- Please complete **ALL** sections of this form. If any section is left incomplete, your registration may be delayed or even rejected.
* All patients over 16 years of age must complete a registration form and sign it themselves.
* If you are on **repeat medication**, please provide a repeat slip from your previous surgery. Unfortunately for patient safety reasons, we **cannot accept hand written lists.**
* If you would like to be able to order repeat prescriptions, make and cancel appointments and be able to look at your own medical record, please ask at reception for an on line access form (ID will be required).
* Please can you provide an up to date BP reading? Please enter a home reading on your registration form if you have a machine at home. Alternatively, there is a machine in reception for you to use.
* Everyone registered with an NHS GP has a Summary Care Record [SCR]. The SCR contains your name, address, date of birth, NHS Number, your medication, and allergies. It can be used in a number of healthcare settings to improve safety, care and efficiency, and will provide healthcare professionals with information they otherwise would not have. For example, when you're visiting an urgent care centre or being admitted to hospital, staff could view your SCR and discover you are on a particular medication or have allergies, but only with you specific permission. We are also offering an enhanced summary record, and this enables clinicians to also see:-
  + - Significant medical history (past and present)
    - Reason for medication
    - Anticipatory care information (concerning management of long term conditions)
    - Communication preferences
    - End of life care information
    - Immunisations

The enhanced summary care record is particularly useful to clinicians in the case of people with complex or long term conditions, or patients reaching end of life.

If you wish to opt out of the Summary Care Record scheme, please ask a receptionist for the form to complete.

|  |  |  |  |
| --- | --- | --- | --- |
| Proof of residence provided (tick) |  | Type of proof | |
| Person checking proof of address |  | | Date |

**For practice use only**

TITLE: …………………………

FIRST NAME(S):…………………………………………………… PREFERRED FIRST NAME: …………………………….

SURNAME: ………………….......................................... DATE OF BIRTH: ……………………………..

GENDER: FEMALE / MALE

ADDRESS: ………………………………………………………………………………………………………………………………………….

POST CODE: …………………… TELEPHONE: …………………………………...

E-MAIL: ……………………………………………………….. MOBILE: ………………………………………....

PREFERRED METHOD OF CONTACT: …………………………….

We may use your contact preference in the future to send you non direct care information like newsletters. If you wish to withdraw consent for this please tick this box

If you consent now and then in the future want to withdraw your consent, please contact the practice and speak to the Practice Manager who can arrange this for you.

MAIN LANGUAGE: ……………………………. INTERPRETER REQUIRED: YES/NO

DO YOU HAVE ANY SPECIFIC INFORMATION OR COMMUNICATION NEEDS RELATED TO A DISABILITY OR SENSORY LOSS? [PLEASE SPECIFY]

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

|  |  |
| --- | --- |
| **Ethnic Origin \***  *Knowing your ethnic origin is important for some of our tests and may affect which medicines work best for you.* | *White*  British  Irish  Other  *Asian / Asian British*  Indian  Pakistani  Bangladeshi  Other  *Black / Black British*  Caribbean  African  Other  *Other/Other British*  Chinese  Other |
|  | *Other (please specify)* |
| **Religion \***  *Why do we ask this? Some religions do not allow certain medical procedures i.e. blood transfusions.* | *Please state if you do not follow a religion* |

HAVE YOU BEEN REGISTERED AT SELDEN MEDICAL CENTRE BEFORE?:……………………………….

**NEXT OF KIN / EMERGENCY CONTACT**

FULL NAME(s): ………………………………………….. RELATIONSHIP(s) TO YOU: ……………………………………

CONTACT NUMBER(s):……………………………….

FULL ADDRESS………………………………………………………………………………………………………………………………………

**PATIENT PARTICIPATION GROUP [PPG]**

Using surveys, the Patient Reference Group helps the practice decide and prioritise changes and improvements in the services we offer. Most of the communication will be via email, but will also be available on the practice website and in the surgery itself. If you would like to participate, please ensure we have your e-mail address and tick the box. If you change your mind and want to withdraw consent at a later date, please contact the practice and speak to the Practice Manager

**PLEASE INDICATE IF ANY OF THE FOLLOWING RELATE TO YOU**

|  |  |  |
| --- | --- | --- |
| HOUSEBOUND | YES | NO |
| WHEELCHAIR USER | YES | NO |
| DO YOU HAVE A CARER | YES | NO |
| ARE YOU A CARER | YES | NO |
| LASTING POWER OF ATTORNEY |  |  |
| WELFARE | YES | NO |
| PROPERTY/FINANCE | YES | NO |

**PAST AND/OR PRESENT MEDICAL HISTORY**

|  |  |  |
| --- | --- | --- |
| **CONDITION/DIAGNOSIS** | **DATE OF ONSET** | **ONGOING/RESOLVED** |
|  |  |  |

**NHS ELECTRONIC PRESCRIPTION SERVICE**

The Electronic Prescription Service (EPS) is a free NHS service which allows GP Surgeries to send your prescriptions to your chosen pharmacy via a secure electronic connection. Please indicate the pharmacy for your prescriptions to be sent to (This can be any pharmacy, no matter how far away they are from the practice as long as the name and postcode are stated).

Hobbs Pharmacy [ ]

East Worthing Pharmacy (previously Hudda) [ ]

Boots (Waitrose) [ ]

Boots (Montague Street) [ ]

Boots (Lyons Farm) [ ]

Other (please state name and post code):

**FAMILY HISTORY**

**Do you have any relatives who have had any of the following?**

|  |  |  |  |
| --- | --- | --- | --- |
| Angina | YES / NO | Relationship(s) |  |
| Cancer | YES / NO | Relationship(s) |  |
| Diabetes | YES / NO | Relationship(s) |  |
| Heart Attack | YES / NO | Relationship(s) |  |
| Stroke | YES / NO | Relationship(s) |  |

**ALLERGIES**

**Do you have any allergies or intolerances?**

|  |  |  |
| --- | --- | --- |
| Allergy/Intolerance | Date of onset | Reaction |
|  |  |  |
|  |  |  |
|  |  |  |

**HEIGHT, WEIGHT & BP** - if you are unable to provide these, the reception staff are able to help you.

**Height:** feet & inches:………………….or Metres & centimetres:…………………….

**Weight:** st. & lbs:……………………..or Kilos:………………………

**Blood Pressure:** Diastolic………… Systolic………… Pulse…………..

**SMOKING** Please circle the following which applies to you and give details:

**Never smoked**

**Ex-smoker** type & amount daily (if you remember):……..………………………

**Current smoker** type & amount on a daily basis:…………………………………………..

**The practice is able to offer smoking cessation services and support**

**If you are a smoker would you like help to stop smoking**: YES / NO.

**ALCOHOL**

(Please circle the answer which applies to each question)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | 0 | 1 | 2 | 3 | 4 |
| How often do you have a  drink that contains alcohol? | Never | Monthly or  less | 2 – 4 times per  month | 2 – 3 times per  week | 4+ times per  week |
| How many units of alcohol  do you have a day, when  drinking? | 1 -2 | 3 - 4 | 5 - 6 | 7 - 8 | 10+ |
| How often have you had 6  or more units on one  occasion, in the last year? | Never | Less than  monthly | Monthly | Weekly | Daily or almost  daily |

**Please note that by signing this form you are agreeing that all of the information which you have provided is correct to your knowledge.**

SIGNATURE:……………………………………………….. DATE:…………………………………….