PATIENT REGISTRATION FORM

Welcome to our practice. Before completing these forms, please confirm that you live within our catchment area. This encompasses all of SE24 but only specific roads in the adjoining postcodes.

As a new patient to this practice we would find it helpful if you would answer the questions on the following pages as it will take some time for your medical records to arrive.

PERSONAL INFORMATION

First Name: **Surname:**

Date of Birth: **Age:**

Address:

Postcode:

Occupation:

TELEPHONE CONTACT DETAILS

We have a text reminder service which can send you a text the evening before your appointment to remind you of the time. In order to receive this service, we must be provided with your mobile number. We may also text this number to invite you to the surgery or request information.

Mobile Number:

The surgery may use this number to contact you, in the interests of confidentiality, **please provide a personal mobile number**. We will use mobile numbers provided for the purposes detailed above.

Home Number:

Work Number (for emergency use only)**:**

EMAIL CONTACT DETAILS

We plan to start to use email more as a form of communication with our patients to reduce our practice paper usage. We would not send any clinical data via this means, but would like to be able to use it to invite you to the surgery or request information.

Email address:

The surgery may use this email address to contact you, in the interests of confidentiality, **please provide a personal email address** to which only you have access. We will use email addresses provided for the purposes detailed above, no clinical data will be sent to your email address.

Please note: The internet is not a secure medium for communication. We cannot guarantee that any information sent by email will arrive safely or be secure from interception by third parties.

NEXT OF KIN

(please provide details of your next of kin in the event that they need to be contacted in an emergency)

Name: **Relationship:**

Contact No:

CARERS

If you are a carer or if you have somebody who cares for you, please ask for a copy of our carers leaflet and complete the appropriate form/s.

BLOOD BORNE VIRUS SCREENING TEST

All new patients at Herne Hill Group Practice are now offered a blood test to look for viruses that can be found in the blood. These viruses are *Hepatitis B*, *Hepatitis C* and *HIV*, all of which can be difficult to diagnose as it is possible to be infected without showing any signs of illness. The combined test for these is the blood borne virus (BBV) test, which means you only need one blood test.

If you would like any further information about this test, please ask reception for a leaflet. If after reading the leaflet you would like to speak to a clinician regarding this test please ask for a new patient check.

Would you like a BBV screening test?
(please tick the appropriate box and answer the linked questions)

☐ **Yes** The receptionist will book you an appointment for the test to be done. You may be asked to come in to discuss your results.

☐ **No**

- Please state your reason for refusing this test:

☐ **Not at risk** ☐ **Recent test** ☐ **Do not want at GP surgery.** ☐ **Do not want blood taken.** ☐ **Other** (please state below)

Please turn over and complete the reverse side.

MEDICAL HISTORY

Your current or past health and the family history of certain conditions can affect your risk of further health problems and how we treat current problems. To assist us in properly managing any current conditions in the time before your medical records arrive, please complete the following tables.

Do you suffer from any of the diseases listed below?

(please tick all that apply and list the date of first diagnosis unless otherwise specified)

Disease		Date	Disease		Date
Hypertension	☐		CHD	☐	
Rheumatoid arthritis	☐		Heart Failure	☐	
Chronic renal disease	☐		Stroke or TIA	☐	
Atrial fibrillation	☐		Hypothyroid	☐	
Diabetes	☐		HIV	☐	
Asthma	☐		Anxiety/Depression	☐	
COPD	☐		Dementia	☐	
Epilepsy (if so date of last seizure)	☐		Schizophrenia, bipolar or other psychoses	☐	

Have you or anyone in your family suffered from Cancer?

Do you suffer from Cancer?		Has anyone in your family suffered from Cancer?		
Where? (e.g. skin/breast)	Date	Where?	Which Relative?	At what age?

Women aged 25-64 only: Have you had a smear in the last 5 years?

(please tick the appropriate box and complete the linked sections)

☐ **Yes**

Date of test: **Result:**

- Was this test taken in the UK? **Yes** ☐ **No** ☐

☐ **No**

- Have you had a hysterectomy?
  Yes ☐ (please provide the date) **Date:**
  No ☐

Are you allergic to any drugs?

(please tick the appropriate box and answer the linked questions)

☐ **Yes**

- To what are you allergic? (please list)

☐ **No**

Do you have any other allergies? (please list)

LIFESTYLE

Many factors can affect your health and your risk of further health problems. Please help us provide relevant advice to you by answering the following questions.

What is your smoking status?

(please tick the appropriate box and answer the linked questions)

☐ **Never Smoked**

☐ **Ex-smoker**

- How many did you smoke? (per day)
- How long were you a smoker?
- When did you give up?

☐ **Current Smoker**

- How many do you smoke? (per day)
- How long have you been a smoker?
- Please indicate if you would like our stop smoking nurse to contact you with information about the advice and support she can provide.
  Yes ☐ **No** ☐

Do you drink alcohol?

(please tick the appropriate box and answer the linked questions)

☐ **No**

☐ **Yes**

- How often do you have 8 (men) / 6 (women) or more drinks on one occasion? (1 drink = 1 unit = 1 small glass of wine / ½ pint beer / 1 single spirit)
  ☐ **Never** ☐ **Less than Monthly** ☐ **Monthly** ☐ **Weekly** ☐ **Daily or almost daily**
- How often during the last year have you been unable to remember what happened because you had been drinking?
  ☐ **Never** ☐ **Less than Monthly** ☐ **Monthly** ☐ **Weekly** ☐ **Daily or almost daily**
- How often during the last year have you failed to do what was normally expected of you because of drinking?
  ☐ **Never** ☐ **Less than Monthly** ☐ **Monthly** ☐ **Weekly** ☐ **Daily or almost daily**
- In the last year, has a relative or friend, a doctor or other health worker been concerned about your drinking or suggested you cut down?
  ☐ **No** ☐ **Yes, on one occasion** ☐ **Yes, on more than one occasion**

BODY MASS INDEX AND BLOOD PRESSURE

Please ask our Receptionist for a token to use our BMI and BP Monitor (located to the right of the reception desk). Follow the instructions on the monitor and make a note of the results from the slip in the appropriate space below.

Weight (in kg): **Height (in cm):**

Maximum Systolic (mmHg): **Minimum Diastolic (mmHg):**

Ethnicity & First Language

I do NOT wish to fill in this information ☐
(please tick this box so that we can make note of your refusal)

What do you consider to be your national identity?

What is your country of birth?

What is your main spoken language?

Please indicate if any of the following statements apply to you.
(please tick all that apply)

- ☐ **I need an interpreter or translator.**
- ☐ **I need large print.**
- ☐ **I use lip reading.**
- ☐ **I use textphone/Minicom.**
- ☐ **I rely on British Sign Language.**
- ☐ **I can read English.**

What language do you prefer to read?

What is your religion? (please write in or tick the box)

Religion: **Religion None** ☐

What is your ethnic group?
Please choose ONE selection only from A to E. In that section, please tick the most relevant box. If you tick a box marked other, please write the name of the ethnic group in the space given.

A. Asian or Asian British

- ☐ **Bangladeshi**
- ☐ **Indian**
- ☐ **Pakistani**
- ☐ **Any other Asian background.** (please write below)

B. Black or Black British

- ☐ **African**
- ☐ **Caribbean**
- ☐ **Any other Black background.** (please write below)

C. Chinese or Other Ethnic Groups

- ☐ **Chinese**
- ☐ **Any other ethnic group.** (please write below)

D. Mixed Background

- ☐ **White & Asian**
- ☐ **White & Black African**
- ☐ **White & Black Caribbean**
- ☐ **Any other Mixed background.** (please write below)

E. White

- ☐ **British**
- ☐ **Irish**
- ☐ **Any other White background.** (please write below)

Help
Do you need help to fill in the form? *Please talk to our Receptionist*

What To Do Next
Have you completed the form? *Please hand it back to the Reception*

You will be offered a new patient check which can help us to properly manage any current conditions in the time before your medical records arrive and assess your current health.

Thank you for your time and co-operation.
Herne Hill Group Practice

For Office Use
Initials of staff checking form:

Patient booked for new patient health check

☐ **No** ☐ **Yes** **Date:** **Time:**

Patient booked for BBV screening test

☐ **Yes** **Date:** **Time:**
BBV screening information given ☐

☐ **No** **Patient refused testing**

Patient to be invited for lifestyle advice?

☐ **Yes** ☐ **No**

Please complete the NHS GP registration form on the reverse side.

NHS

Family doctor services registration

GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ☑ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname ....

Date of Birth ☐☐☐☐☐☐

First names ....

NHS No. ☐☐☐☐☐☐☐☐☐☐

Previous surname/s ....

☐ Male ☐ Female

Town and country of birth ....

Home address ....

....

Postcode

Telephone number

Please help us trace your previous medical records by providing the following information

Your previous address in UK ....

Name of previous doctor at that address ....

Address of previous doctor ....

If you are from abroad

Your first UK address where registered with a GP ....

....

If previously resident in UK, date of leaving

Date you first came to live in UK

If you are returning from the Armed Forces

Address before enlisting ....

....

Service or Personnel number

Enlistment date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

☐ I live more than 1 mile in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

* Not all doctors are authorised to dispense medicines

☐ **Signature of Patient** ☐ **Signature on behalf of patient** Date

....

Version 01/02

Please see right re: Organ donation

NHS

GSM1

NHS Organ Donation registration

I would like to join the NHS Organ Donation Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate.

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming consent to organ donation **Date**

....

For more information, please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk, or call 0845 60 60 400.

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and who would be prepared to donate blood.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register **Date**

....

For more information, please ask for the leaflet on joining the NHS Blood Donor Register.
My preferred address for donation is: (only if different from above e.g. your place of work)

.... Postcode: ....

To be completed by your doctor

Doctors Name HA Code

....

☐ I have accepted this patient for general medical services

☐ For the provision of contraceptive services

☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above* HA Code

....

☐ I am on the HA CHS list and will provide Child Health Surveillance to this patient **or**

☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above* HA Code

....

☐ I will dispense medicines/appliances to this patient subject to Health Authority's

....

☐ I am claiming rural practice payment for this patient.
Distance in miles between my patient's home address and my main surgery is

....

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An Audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name

Date

Practice Stamp

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice