New Patient Registration Form

Welcome to Stanford Medical Centre. As part of the registration process with this surgery, we ask that you please complete this registration form as fully as possible.

Online Access: Registering for Online Access allows you access to pre-bookable and same day appointments, repeat prescriptions and summary care records. We contact our patients via phone, email and post for appointment reminders, service updates and clinical correspondence Please ensure you keep all your contact information up to date and we ask you let us know of any changes.

Once complete please return this form along with a form of **PHOTO ID** and a **CURRENT PROOF OF ADDRESS**.

*All sections in this form marked with an * are compulsory, we will not be able to process your registration without this information.* ***Please complete this form in BLOCK CAPITALS****.*

***TITLE:**	
***FIRST NAME:**	
***SURNAME:**	
***GENDER:**	
PERSONAL PRONOUNS (e.g. she/hers, he/his, they/theirs):	
***DATE OF BIRTH:**	
***NHS NUMBER:** Obtainable via your current GP	
***TOWN AND COUNTRY OF BIRTH:**	
***HOME ADDRESS:**	
***POST CODE:**	
LANDLINE NUMBER:	
***MOBILE NUMBER:**	
EMAIL ADDRESS:	

TO HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS, PLEASE PROVIDE THE FOLLOWING DETAILS:

***YOUR PREVIOUS ADDRESS IN THE UK:**	
***NAME OF PREVIOUS GP/PRACTICE:**	

IF YOU ARE FROM OVER SEAS:

***YOUR FIRST ADDRESS WHERE REGISTERED WITH A GP:**	
***DATE YOU FIRST CAME TO LIVE IN THE UK:**	
***ARE YOU STAYING IN THE UK FOR LONGER THAN 6 MONTHS?**	

***IF PREVIOUSLY A RESIDENT IN THE UK, DATE OF LEAVING:**	

IF YOU ARE RETURNING FROM THE ARMED FORCES:

***ADDRESS BEFORE ENLISTING:**	
***ENLISTMENT DATE:**	
***SERVICE OR PERSONNEL NUMBER:**	

Emergency Contact Details: (PLEASE NOTE UNDER 16'S MUST PROVIDE TWO EMERGENCY CONTACTS)

***EMERGENCY CONTACT 1 (TITLE/NAME/RELATIONSHIP/TELEPHONE)**	
***EMERGENCY CONTACT 2 (TITLE/NAME/RELATIONSHIP/TELEPHONE)**	

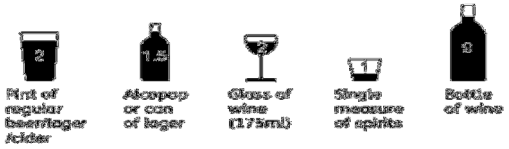
CARERS:

DO YOU HAVE A REGISTERED CARER? **IF YES PLEASE PROVIDE NAME AND CONTACT INFORMATION:**	
ARE YOU A REGISTERED CARER? **IF YES PLEASE PROVIDE NAME AND CONTACT INFORMATION OF THE PERSON YOU CARE FOR:**	

PRESCRIPTIONS: Please bring your repeat prescription slip with you to your first GP appointment

ARE YOU CURRENTLY PRESCRIBED ANY MEDICATION? **IF YES PLEASE SPECIFY**	
WOULD YOU LIKE ANYONE TO COLLECT YOUR PRESCRIPTIONS ON YOUR BEHALF? IF YES PLEASE SPECIFY:	
THE PRACTICE PROVIDES THE EPS (ELECTRONIC PRESCRIBING SERVICE). THIS ALLOWS US TO SEND PRESCRIPTIONS ELECTRONICALLY TO A PHARMACY OF YOUR CHOICE. PLEASE PROVIDE THE DETAILS OF THE PHARMACY YOU WISH YOUR PRESCRIPTIONS TO GO TO:	

HEALTH QUESTIONNAIRE:

***HEIGHT:**		***WEIGHT:**		***BLOOD PRESSURE:**	
DO YOU DRINK? IF YES… **HOW MANY UNITS OF ALCOHOL DO YOU CONSUME IN ONE WEEK?**					
UNITS:					
DO YOU CURRENTLY SMOKE?	YES	NO	**IF YES, HOW MANY DO YOU SMOKE A DAY?**		

HAVE YOU EVER SMOKED?	YES	NO	**IF YES, WHEN DID YOU STOP SMOKING?**	
WOULD YOU LIKE TO RECEIVE SMOKING CESSATION ADVICE?	YES	NO	**PLEASE SPEAK TO OUR RECEPTIONISTS ABOUT OUR STOP SMOKING SERVICE**	

MEDICAL HISTORY:

***ARE YOU CURRENTLY, OR HAVE YOU EVER SUFFERED FROM ANY SIGNIFICANT HEALTH CONDITIONS?** FOR EXAMPLE: HEART DISEASE/HIGH BLOOD PRESSURE/STROKE/ASTHMA/DIABETES/COPD/CHRONIC KIDNEY DISEASE/MENTAL-HEALTH/LEARNING DISABILITIES/EPILEPSY/CANCER	☐ **'YES'** Please specify: _____ **If you have answered 'YES'** please can you make a **20 minute** 'New Patient' appointment with Practice Nurse **Sarah, Eileen or Maddie**.

ALLERGIES:

PENICILLIN ALLERGY	☐	**EGG ALLERGY**	☐	**If 'OTHER' please can you specify which and if you are currently on any medication for this:**
PEANUT/NUT ALLERGY	☐	**ANIMAL ALLERGY**	☐	_____
FOOD ALLERGY	☐	**OTHER ALLERGY:**	☐	_____

OTHER HEALTH CONCERNS:

DO YOU HAVE A PHYSICAL DISABILITY?	YES	NO	**IF YES PLEASE SPECIFY:**	
ARE YOU VISUALLY IMPAIRED?	YES	NO	**IF YES DO YOU REQUIRE LARGE PRINT DOCUMENTS?**	
DO YOU HAVE HEARING DIFFICULTIES?	YES	NO	**THIS PRACTICE HAS A HEARING LOOP**	

***ETHNIC ORIGIN:**

☐ WHITE BRITISH	☐ IRISH	☐ PAKISTANI	☐ OTHER ETHNIC GROUP – PLEASE SPECIFY
☐ WHITE OTHER	☐ INDIAN	☐ WEST INDIAN	
☐ BLACK AFRICAN	☐ BANGLADESHI	☐ IRANIAN	☐ I DO NOT WISH TO DISCLOSE THIS INFORMATION
☐ BLACK OTHER	☐ CHINESE	☐ ARAB	

***MAIN SPOKEN LANGUAGE:**

☐ ENGLISH	☐ FRENCH		☐ TURKISH	☐ PORTUGUESE
☐ ARABIC	☐ MANDARIN		☐ POLISH	OTHER:
DO YOU REQUIRE AN INTERPRETER?	YES	NO	IF YES, WHICH LANGUAGE DO YOU REQUIRE?	

***SUMMARY CARE RECORDS**

☐ YES – I consent to my GP creating a Summary Care Record for me and uploading it to the National Electronica Database: (this includes only limited information i.e. Current Medications & Allergies)

If you wish to choose the option to have a summary care record with additional information uploaded, please tick the box below (this included Current medications, allergies and any active problems) – If you would like further information about this please ask at reception.

Signature:

☐ NO – I do not consent for my GP creating a Summary Care Record for me and uploading it to the National Electronic Database

Signature:

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from any bad reactions to medicines you have had, in order to treat you safely in an emergency. Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please:

Phone the Summary Care Record Information Line on 0300 123 3020

Contact your local Patient Advice Liaison Service (PALS) or

Contact your GP Practice

***Consent**

PRINT NAME: SIGNATURE:	Date:

I declare to the best of my belief that the information I have provided is correct, and do consent for the appropriate use of this information by Practice Staff.