NHS

The Stanford Medical Centre

New Patient Registration Form

Welcome to Stanford Medical Centre. Please complete this registration form as fully as possible. Once complete please return this form along with a form of **PHOTO ID** and a **CURRENT PROOF OF ADDRESS**.

To be checked by the reception team:

ID ☐ Proof of Address ☐ NHS no. ☐ Contact Details ☐ Emergency Contact ☐ SCR ☐		Initials:
Preston Road ☐ Islingwood Road ☐ Cockcroft ☐	Date:	Registered ☐ Online ☐ Emailed ☐

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

***Title:** eg: Mrs, Dr, Mx:			***Date Of Birth:**	D D / M M / Y Y Y Y	
***First Name:**			***Surname:**		
Pronouns: eg: She/Her, They/Their:			**Gender Identity:** eg: male, non-binary:		
***Sex Assigned at Birth:**	☐ Male	☐ Female	☐ Intersex	**Sexuality :**	
We ask for your assigned sex to help us screen for sex-specific diseases such as cervical/prostate cancer.					
***NHS Number:** Obtainable via your current GP					
***Ethnic Origin:**				☐ I do not wish to disclose.	
***Main Spoken Language:**					
***Do You Require An Interpreter:**	☐ Yes ☐ No		Unfortunately we are unable to book an interpreter for same day appointments.		
***Town And Country Of Birth:**					
***Home Address:** (In Brighton)					
***Post Code:**					
***Mobile Number:**			**Landline Number:**		
Email Address:					

Providing an email will sign you up for online access on which you can book appointments and see test results and immunisation history. Once you are registered your log in details will be sent via email. **Not available for under 16s.**

Previous Medical Details:

***Your Previous Address In The UK:**	
***Name Of Previous GP/Practice:**	

If You Are From Over Seas:

***The first address you were registered with a GP:**	
***Date you first came to the UK:**	
***If previously a resident, date of leaving the UK:**	

***Emergency Contact Details:** You must have a contact in the UK. Children with two guardians/ next of kin need both.

Are you studying with the University of Brighton International College?		☐ Yes ☐ No
***Title and Full Name:**		
***Relationship to you:**		
***Contact Number:**		
***Is this person your next of kin:**	☐ Yes ☐ No	☐ Yes ☐ No

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

Please provide the details of the pharmacy you wish your prescriptions to go to:		
Please tell us if you need your medication to be:	☐ Vegetarian	☐Vegan

***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:	

Power of Attorney: If there is any power of attorney in place, please provide reception with the documents of proof.

***Health Questionnaire:**

***Height:**		***Weight:**		***Blood Pressure:**	

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 suffering from any significant health conditions?** Which require monitoring or medication? If yes, you may need to come in for a 20 new patient appointment with the Practice Nurse Sarah, Eileen or Maddie. Please ask the reception team.	☐ Yes ☐ No Please Specify:

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:	

Adaptations:

Are you visually impaired?	Yes	No	**If Yes, do you require large print documents?**	Yes	No
Do you have hearing difficulties?	Yes	No	This Practice Has A Hearing Loop		

Please talk to reception about any other measures we could take in order for you to help you with your requirements.

***Summary Care Records**

☐ YES – I consent to my GP creating a Summary Care Record for me and uploading it to the National Electronic Database: (this includes only limited information i.e. Current Medications & Allergies) ☐ YES – I consent to my GP creating a Summary Care Record **with additional information** for me and uploading it to the National Electronic Database: (this included Current medications, allergies and any active problems) **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 you DO NOT have a Summary Care Record? NHS healthcare staff caring for you may not be aware of your current medications, allergies, or bad reactions to medicines you have had, in order to treat you safely in an emergency. Your records will stay being shared by letter, email, fax or phone. If you have any questions, or if you want to discuss your choices: Phone the Summary Care Record Information Line on 0300 123 3020, contact your local Patient Advice Liaison Service (PALS).

***Consent** 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.
Consent to receive SMS notification for non-clinical services: ☐ Yes ☐ No
Consent to receive email notification for non-clinical services ☐ Yes ☐ No

Print Name:			
Signature:		**Date:**	

If you have completed this form correctly and provided an email address you will receive an email confirming your registration and welcoming you to the practice. You will also receive your online access information separately. For an information leaflet or to set up online access in person, please talk to the reception team.