York Surgery
New Patient Registration Form

Today's Date:

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Please complete a separate form for each family member to be registered.

Full Name:		Gender: Male☐ Female ☐
Date of Birth: _ _/ _ _/ _ _ _ _	Marital Status:	Mr☐ Mrs☐ Miss☐ Ms☐ Other ……
Place of Birth:	Ethnic Origin:	
Address and Postcode:	Please place an **X** next to preferred contact number.	
	Mobile Number: ☐	
	Home Number: ☐	
	SMS consent: Yes ☐ No ☐	
In the event of short notice, we may send you an email to bring your attention to an urgent matter. Please delete as appropriate. ☐ I wish to be contacted by email as an alternative method of contact in writing. My email address is ……. ☐ I do not wish to be contacted by email.		
Next of Kin:	Next of Kin Contact Number:	
Main Spoken Language:	Do you easily speak English? Yes ☐ No ☐ If no, do you need the help of interpreter? Yes ☐ No ☐	

Smoking, Alcohol Consumption and Exercise:					
Are you currently a smoker?	**Yes**	**No**	**Have you ever been a smoker?**	**Yes**	**No**
If so, how many cigarettes / cigars / tobacco do you smoke in a week?			**How much alcohol do you drink in a week (Units)?** *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)*		
If you are a smoker and want to stop, please ask for information about local smoking cessation services.					

Your Medical Background:

Please make a routine appointment with one of the practice GPs to discuss any regular medication that you are currently taking.

Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)	Diabetes	Heart Attack	Heart attack under age of 60	Bowel Cancer	
	Breast Cancer		High Blood Pressure	Asthma	Stroke
	Thyroid Disorder		Any other important Family Illness?		

What immunisations have you had?	Please attach a copy of the patient immunisations list to this registration form. (Only applicable to children under the age of 6 years)

Specific Needs:

Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:

Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):		
Are you an 'Assistance Dog' User?		
Please state any Physical disabilities you have:		
Please state any Mental disabilities you have:		
If you are a Carer, please state the name / address / phone number of the person you care for:	**Person Cared For Contact Details:**	
If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer Contact Details:** **Do you consent to sharing your medical information with your carer?** Yes ☐ No ☐ **Signed:** **Date:**	
Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	Yes ☐ No ☐	*If "Yes", can you please provide a written copy of it to the practice?*
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	Yes ☐ No ☐	If "Yes", please state their name / address / phone number:

Please note that details regarding 'Living Will' and Power of Attorney related to your health only will only be entered on your patient's records once a copy of the official evidence has been provided to the Practice.

Women only:			
When was your last smear done?	Date	Was this at your GP's Surgery?	Yes ☐ No ☐
What was the result of the smear?		Date of last mammogram (if applicable):	Date

Summary Care Records.

The NHS are changing the way your health information is stored and managed.
The NHS Summary Care record is an electronic record of important information about your health.
It will be available to health care staff providing your NHS Care. An information pack has been provided.

Are you happy to have a Summary Care Record?	Yes	No	More Time Required to decide:

Patient Participation Group

The Practice is committed to improving the services we provide to our patients.
To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.
By expressing your interest, you will be helping us to plan ways of involving patients that suit you.
It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.
If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.

Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box)	Yes

Patient Signature:		Signature on behalf of Patient:	

Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).

The Consultation will also establish relevant past medical and family history, including:

- ***Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health***
- ***Social factors - employment, housing, family circumstances***
- ***Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.***

Thank you for completing this form