Hawkley Brook Medical Practice

New Patient Registration Forms – ADULTS

Please complete this confidential questionnaire, it has been designed to help us get to know you and your medical problems.

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

Full Name:	**Date of Birth:**
Marital status:	**Children's names (under 21y)** **DOB** **1-** **2-** **3-** **4-**
Next of Kin + relationship:	**Next of Kin / Emergency contact number:**
If you are employed, what is your occupation?	**If you are unemployed is this related to your health?** Give details:
Are you a smoker? Yes / No Cigarettes / Pipe / Tobacco **If yes how many per day?** **If yes would you like help to stop?** Yes / No	**Do you drink alcohol?** Yes / No **If yes how many units per week?** Give details:

Your Religion:	**C of E**	**Catholic**	**Other Christian (state)**	**Buddhist**	**Hindu**	**Muslim**
	Sikh	**Jewish**	**Jehovah's Witness**	**No religion**	**Other religion (state)**	
Place and Country of Birth						
First Language				**Please indicate if you require the use of an interpreter?** Yes / No		

Ethnicity :

White British ☐	Indian ☐	Black Caribbean ☐	Any Mixed Background ☐
Other White British ☐	Pakistani ☐	Black African ☐	Other Ethnic Group ☐
White Irish ☐	Chinese ☐	Black British ☐	Other ☐
White European ☐	Other Asian ☐	Other Black ☐	Patient Declined ☐

Women only:

Are you using contraception? Yes / No
If yes which type……
When was your last smear test……..
Have you ever been pregnant? Yes / No
If yes how many pregnancies have you had…….

Your Medical Background:					
What illnesses have you had & When?					
What operations have you had and When?					
Do you have any medical problems at present? If so please inform us here					
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)	(Please also bring your repeat prescription or medication with you to your new patient check)				
Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)	**Breast Cancer**	**Heart Attack**	**Heart attack under age of 60**	**Bowel Cancer**	
	Diabetes		**High Blood Pressure**	**Asthma**	**Stroke**
	Thyroid Disorder		**Any other important Family Illness?**		

Specific Needs:	
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 health or learning disabilities you have:	
Please state any requirements you have to be able to access the Practice premises	
Please state any Religious or Cultural needs:	
Please state any allergies and sensitivities you have:	
Please state any phobias you have:	

Carer Information:	Please indicate with a tick in the box if any of the following statements apply: I provide a substantial amount of care to an adult. ☐ I provide a substantial amount of care to a disabled child. ☐ I give permission for my name to be entered on the practice carers register. ☐
Safeguarding:	Have you ever been a "looked after child"? Yes / No
Military veterans:	Have you ever been in the armed forces? Yes / No If yes date left:……

Online services: ordering prescriptions & booking appointments

Would you like to register for online services? Yes/No

You will be given a username and password to use this service

Email address…….

Electronic Prescriptions

Do you have a nominated pharmacy to receive your electronic prescriptions? Yes / No

If yes - Name of pharmacy:……

If no please visit your chosen pharmacy and ask to register for electronic prescriptions.

SMS Text Messaging

If you supply us with a mobile number you will receive text message appointment reminders. If you wish to opt out please discuss this at your new patient check appointment.

Patient Signature:	**Signature on behalf of Patient:**

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or see our website http://www.hawkleybrookmedicalpractice.nhs.uk/

MY INFORMATION SHARING OPTIONS

PLEASE COMPLETE ALL THREE SECTIONS (You are able to change your decision at any time)

Option 1 - Summary Care Record – My Emergency Care Summary

This will be used in emergency care. The record will contain essential information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had, to ensure those caring for you have enough information to treat you safely. If you wish to opt out please discuss this at your new patient check appointment.

Option 2 – Record Sharing

Sharing Out

Do you consent to Hawkley Brook Medical Practice sharing your data with those who are directly involved with your care and using a compatible computer system?

☐ **YES**, I consent to share data with other compatible computer system users involved in my care.

☐ **NO**, I do not consent to share data recorded at Hawkley Brook Medical Practice with other system users involved in my care.

Sharing in

Do you consent to Hawkley Brook Medical Practice viewing any data recorded at other Health Care services that may care for you?

☐ **YES**, I consent to Hawkley Brook Medical Practice viewing data held by other Health Care organisations.

☐ **NO**, I do not consent to share data recorded at other organisations with Hawkley Brook Medical Practice.

Patient Signature…….
Or
Signature on behalf of patient (under 16)……