Hockley Medical Practice
New Patient Registration Form – Over 5years Old

Please complete this confidential questionnaire (one for each member of the family). 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. If your address is outside of the Practice catchment area, please understand that you will not be covered for the following services: Home Visits, Community services including District Nurses, Health Visitor and Community Matron.

1. NAME & CONTACT DETAILS:

Title: *Mr / Mrs / Miss / Ms / Other……..* FULL NAME:	Address: Postcode:
Date of Birth: / Gender: *Male* ☐ *Female* ☐	
Have you previously been removed from a GP Practice under the ZERO TOLERANCE POLICY:	**YES** ☐ **NO** ☐
Gender Assigned at Birth (If different from above): *Male* ☐ *Female* ☐	Have you ever been a member of the Armed services (Navy/Marines/Army/Air Force)?' YES ☐ NO ☐
Mobile Number:	We send appointment reminders on your given mobile number. If you do not want text messaging services, you can opt out by letting us know. Opt In ☐ Opt Out ☐
E-mail Address:	Do you require Online Access for Appointment booking & ordering repeat medication? YES ☐ NO ☐
Home Tel: / Work Tel:	*PROXY ACCESS:* • *Ages 0-10 Parent may request access for online services – ID required* • *Ages 11 to 15 must consent for parents to have online access for them. ID required* • *Ages 16 and over must consent themselves and provide their own ID*
Occupation:	Marital Status: / Previous Surname if different:
Any Dependants (Name & DOB):	Any Children (Name & DOB):
Country & Town of birth:	If county of birth is outside of UK, Date of entry in to UK:
Next of Kin Name:	Next of Kin Relationship: Next of Kin Contact Number:

2. PREVIOUS GP & ADDRESS DETAILS:

PREVIOUS GP NAME:					YOUR PREVIOUS HOME ADDRESS:
Housing (Select one)	House	Maisonette	Flat	Mobile Home	NHS Number (If Known)
If returning from Armed Forces:		Your Service or Personnel Number			Your Enlistment Date:

3. PERSONAL DETAILS:

Your main or 1st language Spoken / Understood: (select one)	English	Hindi	Gujrati	Urdu	Bengali /Sytheti	Punjabi

Polish	Ukrainian	French	German	Spanish	Other: (Please Specify)

Your Ethnic Origin: (select one)	**White (UK) 9i0**	**White (Irish) 9i1%**	**White (Other) 9i2%**
Caribbean 9i3	**African 9i4**	**Asian 9i5**	**Other Mixed Background 9i6%**
Indian / Brit Indian 9i7	**Pakistani / Brit Pakistani 9i8**	**Bangladeshi / Brit Bangladeshi 9i9**	**Other Asian Background 9iA%**
Other Black Background	**Chinese 9iE**	**Other 9iF%**	**Ethnic Category not stated 9iG**

**Do you require an interpreter for appointments at the surgery? YES ☐ NO ☐

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?			*If you are a smoker and want to stop, please ask for information about local smoking cessation services.*		
Do you drink Alcohol?	Yes	No	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)*		

How often do you exercise?	No. times per week?	Type of exercise:	

4. YOUR MEDICAL BACKGROUND:

What illnesses have you had & When?	
What operations have you had and When?	
Do you have any medical problems at present?	
Please list any medication or other treatments you are currently taking:	(include dose + frequency)
Are there any serious diseases that affect your Parents, Brothers or Sisters? *eg: Cancer, Diabetes or Heart Disease*	

5. 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:		
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:		
Are you a Carer?	YES ☐ NO ☐ Relationship: _____	
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:	
	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",* *please bring a written copy of itto your New Patient Consultation*
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: *(You will need to complete a consent form)*

6. Age 5 to 18years only:

Which School/College or University do you attend?	Name: Address:

7. SERVICES & SIGNATURE:

Summary Care, Your Care Connected Records.

The NHS are changing the way your health information is stored and managed. To provide safe health care if you wish, your medical record containing allergies, medications and diagnostics results can electronically be available to acute hospitals in this country. *If you do not wish this to be given please let the staff know*

Are you happy to have a • Summary Care Record? • Your Care Connected?	Yes	No *If no, please ask for a copy of: "Summary care opt Out Form"*	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. If you are interested in getting involved, please tick the box below and give your email address or discuss with staff for more information.

YES ☐	Email address:

****Information from the Patient Participation Group (PPG)****

DNA: DID NOT ATTEND APPOINTMENT

If you cannot attend your appointment, please inform the surgery as soon as possible (minimum 2 hours before) on 0121 554 1757 so that this time may be offered to another patient. You can also cancel appointments in person at the desk or by replying CANCEL to your text reminder. The Practice Manager actively monitors DNA appointments. Failure to cancel appointments will result in the Practice contacting you and repeated missed appointments may result in removal from the Practice list.

Please remember: KEEP IT or CANCEL IT

Patient Signature:		Signature on behalf of Patient:	
Name:		Name:	
Date:		Date:	

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 the attached registration form. To verify your identity, please provide proof of

1) photo ID
2) proof of address.

Please send this via email to: Hockleymedical.admin@nhs.net