STUBLEY MEDICAL CENTRE

New Patient Registration Form

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 where appropriate.

If you are newly arrived in the 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. Please supply ONE form of photo ID and ONE document containing proof of address.

If you are a patient from oversees, please see Reception for further guidance.

Title (please circle) : Mr/ Mrs / Miss / Ms / Other…		**Date of Birth:**	**Sex**
			Female ☐
Other (please specify):			**Male ☐**
First name:	**Surname:**	**NHS Number:**	
Address:		**Home Telephone Number:**	
		Mobile Number:	**I am happy to be contacted via text/SMS messaging ☐**
Postcode:		**E-mail Address:**	**I am happy to be contacted via email ☐**
Previous Address and Postcode:		**Next of Kin:**	
		Next of Kin Contact Number:	

Please help us trace your previous medical record by providing the following information:

Previous GP/ GP Surgery:	**Previous GP address:**
If you are not a British Citizen and have not registered with a GP, please enter the date you first came to live in Britain:	

Have you ever been registered Armed Forces GP?

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas? **(These questions are optional; your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.)**

Regular ☐	Reservist ☐	Army veteran ☐ Military veteran ☐ Royal Air Force veteran ☐ Royal Marines veteran ☐ Royal Navy veteran ☐	Family Member☐

Medical History

<table>
<tr><td>Height:</td><td colspan="2">Weight:</td><td colspan="2">Smoker</td><td>Yes ☐</td><td>No ☐</td></tr>
<tr><td>Do you consume alcohol?</td><td>Yes ☐</td><td>No ☐</td><td rowspan="2" colspan="2">If yes, how many cigarettes/cigars/tobaccos do you smoke in a week?</td><td rowspan="2" colspan="2"></td></tr>
<tr><td>If yes, how many units of alcohol do you consume in a week?
(Example: one 25ml measure of spirit is 1 unit, 125ml glass of wine is 1.5 units, and one pint of lower strength beer is 2 units.)</td><td colspan="2"></td></tr>
<tr><td>How do you like to exercise and how often per week would you say you exercise?</td><td colspan="6"></td></tr>
<tr><td rowspan="3">Are there any serious diseases which have affected your parents or siblings?</td><td colspan="2">Diabetes</td><td colspan="2">Heart Attack</td><td colspan="2">Stroke</td></tr>
<tr><td colspan="2">Cancer (what type)</td><td colspan="2">High Blood Pressure</td><td colspan="2">Asthma</td></tr>
<tr><td colspan="2">Thyroid Disorder</td><td colspan="4">Other…</td></tr>
<tr><td>Do you have any current on ongoing medical problems or illnesses?</td><td colspan="6"></td></tr>
<tr><td>Do you have any allergies or sensitivities?

If so, do you require EpiPens?</td><td colspan="6"></td></tr>
<tr><td>Do you currently take any medication?

If so, please include the dose and frequency of your medication.</td><td colspan="6"></td></tr>
</table>

Are you able to administer your own medication?	Yes ☐	No ☐ Please detail specific reason you cannot administer your own medication, i.e., problems with swallowing or opening packaging.
Apart from some controlled drugs, we send prescriptions electronically to your nominated pharmacy. Please write your nominated pharmacy in the box provided. <u>If you leave this blank your prescriptions will be sent to Peak Pharmacy Stubley Drive.</u>		

Specific Needs

Do you have any sensory, learning, or physical requirements we should be aware of to enable you to have a good experience with our practice?			
Do you require the use of a Translator or Interpreter?	Yes ☐	No ☐	Further details:
Are you a Carer?	Yes ☐	No ☐	Further details:

If you have a Carer, please state their contact details should we need to contact them and if you are happy for us to disclose information about your health to your Carer.	Contact details:	I am happy for my surgery to disclose information about my health to my Carer for the purpose of continuing care. ☐ (Please tick)	
		Signed:	Date:
Have you nominated someone to speak on your behalf i.e., Medical Power of Attorney?	Name and relationship to yourself:	Contact details:	

Summary Care Record (SCR)

The NHS Summary Care Record or SCR is an electronic record of key information about your health which is made available to NHS health care staff when needed to provide you with care. Please visit https://www.nhs.uk/using-the-nhs/about-the-nhs/your-health-records/ to learn more.

Are you happy to have a Summary Care Record?	Yes ☐	No ☐

I confirm the information on this form is correct to the best of my knowledge and wish to register with Stubley Medical Centre:

Patient Signature:

Thank you for completing this form. Please return this to Practice with you ID and proof of address. For more information on the services we offer, please visit our website www.stubleymedical.co.uk or speak to one of our Reception Team.

Staff use only

I confirm I have checked:

Patient ID ☐

Proof of address ☐

Signed: **Date:**