**LAINDON MEDICAL GROUP**

Today’s Date

**NEW PATIENT REGISTRATION FORM (ADULT)**

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| * Please complete this confidential questionnaire (one for each member of the family over 16 years of age 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.
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| Full Name:Mr / Mrs / Miss / Ms / Other: | Telephone Number: |
| Work Number: |
| Address:Post Code: | Mobile Number: |
| Email Address: |
| Next of Kin: |
| Consent to be contacted by text message:**YES / NO** | Next of Kin Contact Number: |
| Date of Birth: | Previous Surname(s): | Town and Country of Birth: |
| Occupation: | Male / Female | Specific Needs, e.g. hearing / visual impairment. Interpreter required: |
| Ethnicity: |
| Religion (optional): | If applicable, date you came to live in Britain: |
| Names and Ages of Children: | NHS Number (if known): |
| Previous Address:Previous Post Code: | Previous GP’s Name, Address and Telephone Number: |
| Alcohol Usage: PLEASE COMPLETE ATTACHED FAST ALCOHOL SCREENING TEST (FAST) FORM |
| Smoking Status: | SMOKER / NEVER SMOKED / EX-SMOKER(delete as necessary) |
| Is there any significant family history (e.g. Asthma / Heart Disease)? | **YES / NO**(delete as necessary) | **If YES**, please give details: |

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| Are you cared for? **YES / NO****If YES**, please give us more information: |  |
| Are you a carer? **YES / NO****If YES**, please give us more information: |  |
| Have you nominated someone to speak on your behalf? (with Power of Attorney)   **YES / NO****If YES**, please state their Name, Address and Telephone Number: |  |
| Do you have any communication difficulties? **YES / NO****If YES**, please give details informing us of what you may require: |  |
| Are you a military veteran? **YES / NO** |  |

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| **SUMMARY CARE RECORDS*** The NHS is 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.
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| Are you happy to share your records with any health care worker your doctor feels is necessary for your medical care? | **YES / NO** |
| Are you happy to have a Summary Care Record? | **YES / NO** |

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| **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 to make services better. By expressing your interests you will be helping us to plan ways of involving patients that suit you. It also means we can keep you informed of opportunities to give your views and keep you up-to-date with developments within the practice.Please indicate below if you are interested in getting involved and, if YES, we will contact you regarding this. |
| I am interested in becoming involved in the Patient Participation Group: **YES / NO**  (delete as necessary) |
| Patient Signature: | Signature on behalf of Patient: |

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| Thank you for completing this form.For more information about the services we offer, please refer to your new patient leaflet or see our website:laindonmedicalgroup.nhs.uk |