**PERSONAL DETAILS**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NEW PATIENT REGISTRATION FORM

**NEXT OF KIN**

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO YOU:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TELEPHONE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ETHNIC ORIGIN**  MAIN SPOKEN LANGUAGE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

White British White, Other Black African Bangladeshi

Black Caribbean Vietnamese Chinese Pakistani

Other – please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***AS A NEW PATIENT, YOU ARE INVITED TO HAVE A REGISTRATION HEALTH CHECK. PLEASE MAKE AN APPOINTMENT WITH ONE OF OUR PRACTICE NURSES. YOU WILL NEED TO BRING A URINE SAMPLE WITH YOU TO THIS APPOINTMENT.***

**PLEASE STATE HERE ANY COMMUNICATION CONSIDERATIONS YOU WOULD LIKE TO MAKE US AWARE OF**:

Blind Learning Disability

Partially sighted Other, please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Deaf

**ARE YOU A CARER?**

Yes No

IF YES:-

NAME OF PERSON YOU CARE FOR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP TO YOU:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DETAILS OF ANY ALLERGIES**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SMOKING STATUS**

Never Smoked Ex-Smoker Current Smoker (please state amount smoked per day)\_\_\_\_\_

*WE STRONGLY RECOMMEND ALL PATIENTS STOP SMOKING AS IT SERIOUSLY DAMAGES YOUR HEALTH.*

**HEIGHT**:\_\_\_\_\_\_\_\_\_\_\_\_ **WEIGHT**:\_\_\_\_\_\_\_\_\_\_\_\_

**ARE YOU CURRENTLY TAKING ANY MEDICATION?**

Yes *(If yes you will need to provide your repeat request slip or make an appointment to see a GP).*

No

**NOMINATED PHARMACY**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Online Registration Form

**Access to GP Online Services**

Patient online has been designed to support our patients by providing access to online services which include things like, booking and cancelling appointments, ordering your repeat prescription and viewing certain parts of your medical record.

To gain access to your online account the below registration form must be completed and handed back to the receptionist.

Our practice policy ensures that all applications for online registration will be reviewed, we aim to complete your registration within 2 weeks. Please contact the surgery to confirm if you have not been notified within 2 weeks.

Please complete the following:

|  |  |
| --- | --- |
| Surname |  |
| First name |  |
| Date of birth |  |
| Address |  |
| Postcode |  |
| Email address |  |
| Telephone number(s) |  | Mobile number |  |
| May we contact you via text message? | YES / NO |

I wish to have access to the following online services (tick all that apply):

|  |  |
| --- | --- |
| 1. Booking Appointments |  |
| 2. Requesting repeat prescriptions |  |
| 3. Accessing my summary (medication, allergies, sensitivities) |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature |  | Date  |  |

*In the event of an approval of your online application, we hope that online services provided to you are beneficial. Some patients however (e.g. who suffer from a long term condition or require regular monitoring of their condition) may find that having access to more detailed information within their medical record is required. If you feel that this applies to you, please ask the receptionist for another registration form to request access to detailed coded information.*

**ALCOHOL QUESTIONNAIRE**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **Score****0** | **Score****1** | **Score****2** | **Score****3** | **Score** **4** | **Your Score** |
| **How often do you have a drink that contains alcohol?** | **Never** | **Monthly or less** | **2-4 times per month** | **2-4 times per week** | **4+ times per week** |  |
| **How many standard alcoholic drinks do you have on a typical day when you are drinking?** | **1-2** | **3-4** | **5-6** | **7-8** | **10+** |  |
| **How often do you have 6 or more standard drinks on one occasion?** | **Never** | **Less than monthly** | **Monthly** | **Weekly** | **Daily or almost daily** |  |

 **TOTAL:**

**DRINKING WITHIN THE LOWER RISK GUIDELINES**

**Men should not exceed 3-4 units per day on a regular basis**

**Women should not exceed 2-3 units per day on a regular basis**

Drinking within the lower risk guidelines means that in most circumstances

you have a low risk of causing yourself future harm

**Family Member Form**

Please fill out the form below with all your family members’ details living at the above address.

|  |  |  |
| --- | --- | --- |
| **Name** | **D.O.B.** | **Relationship to patient** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Carmel medical Practice**

Every patient is now allocated a named GP. This may be different from the GP you usually see. This does not change the way you book appointments. It means that one GP will have overall responsibility for your care at the surgery. The practice will make reasonable efforts to accommodate any requests regarding any preferences to be with a specific GP. Should you wish to know your named GP please contact Reception.

**Consent for use of SMS TEXTING**

The Practice may wish to contact you by SMS Texting to remind you about a forthcoming appointment.

•I agree to the Practice communicating with me by Short Messaging Service (SMS

or Text)

•I confirm that the mobile number the Practice holds on my record is correct and

I will notify them of any changes.

•I agree to receive a reminder of my appointment by SMS.

•I am aware that I can withdraw consent at any time by informing the Receptionist either verbally or in writing.

Name...................................................................................................

Signature..............................................................................................

**Carmel Medical Practice Patient Participation Group**

Would you like to join our Patient Participation Group? The role of the group is

* To advise the practice on the patient perspective
* To carry out research into the views of those who use the practice (and their carers if appropriate) and feedback to the practice, without naming the patients, positive or negative comments without prejudice.
* To work with volunteer services, when the need arises, and support groups to meet local needs
* To attend and participate at PPG meetings held once every three months lasting approximately 1 hour.

The meetings are friendly and informal

If you would like to become a member of the Patient Participation Group please fill out your details below.

Name:

Address:

Email Address:

Contact Telephone Number:

Other contact method: