



## New Patient Registration Form

Contact Details - Please complete all pages in full, using block capitals	
Name (IN CAPITALS)	
Date of Birth	
Have you been known by any other name i.e. maiden name, deed poll name change etc. we require this to ensure your NHS record is accurately registered	
Address*	
Relationship Status	
Mobile Telephone*	I consent to be contacted by SMS on this number: Yes <input type="checkbox"/> No <input type="checkbox"/>
Email Address*	I consent to be contacted by email at this address : Yes <input type="checkbox"/> No <input type="checkbox"/>
Preferred method of contact*	Mobile <input type="checkbox"/> Email <input type="checkbox"/> Letter <input type="checkbox"/>

\* It is your responsibility to keep us updated with any changes to your telephone number, email & postal address. We may contact you with appointment details, test results or health campaign.

Next of Kin Details		
Name	Telephone Number	Relationship to you

Other Details				
Ethnicity	White UK <input type="checkbox"/>	Black Caribbean <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Arabic <input type="checkbox"/>
	White Irish <input type="checkbox"/>	Black African <input type="checkbox"/>	Indian <input type="checkbox"/>	Chinese <input type="checkbox"/>
	White Other: <input type="checkbox"/>	Black Other: <input type="checkbox"/>	Pakistani <input type="checkbox"/>	Other: <input type="checkbox"/>
Religion	C of E <input type="checkbox"/>	Buddhist <input type="checkbox"/>	Sikh <input type="checkbox"/>	No religion <input type="checkbox"/>
	Catholic <input type="checkbox"/>	Hindu <input type="checkbox"/>	Jewish <input type="checkbox"/>	Other: <input type="checkbox"/>
	Other Christian: <input type="checkbox"/>	Muslim <input type="checkbox"/>	Jehovah's Witness <input type="checkbox"/>	
Employment	Employed <input type="checkbox"/>	Self-employed <input type="checkbox"/>	Student <input type="checkbox"/>	Unemployed <input type="checkbox"/>
	House husband <input type="checkbox"/>	House wife <input type="checkbox"/>	Carer <input type="checkbox"/>	Retired <input type="checkbox"/>
Armed Forces	Military veteran <input type="checkbox"/> Member of military family <input type="checkbox"/> Left military service <input type="checkbox"/>			

Communication Needs	
Language	What is your main spoken language: Do you need an interpreter? Yes <input type="checkbox"/> No <input type="checkbox"/>
Communication	Do you have any communication difficulties? If yes, please identify Hearing Aid <input type="checkbox"/> Large Print <input type="checkbox"/> British Sign Language <input type="checkbox"/> Lip reading <input type="checkbox"/> Braille <input type="checkbox"/> Other.....

Carer Details *Only add carer's details if they give their consent to have these details stored on your medical record	
Are you a Carer?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have a Carer?	Yes <input type="checkbox"/> No <input type="checkbox"/>



## Your Lifestyle

### Alcohol Screening:

Questions	Scoring system					
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
						Total Score

### Scoring:

Please total your score; a total of 5+ indicates increased / higher risk drinking, we may contact you to discuss this further.

### Smoking

Do you smoke	<input type="checkbox"/> Never smoked <input type="checkbox"/> Ex-Smoker <input type="checkbox"/> Yes
Do you use an e-Cigarette	<input type="checkbox"/> No <input type="checkbox"/> Ex-User <input type="checkbox"/> Yes
How many cigarettes did/do you smoke a day?	<input type="checkbox"/> 1-9 <input type="checkbox"/> 10-19 <input type="checkbox"/> 20-39 <input type="checkbox"/> 40+
Would you like help to quit smoking? If so we can book an appointment with our Smoking Cessation Advisor	Yes <input type="checkbox"/> No <input type="checkbox"/> For further information, please see: <a href="http://www.nhs.uk/smokefree">www.nhs.uk/smokefree</a>

### Height & Weight

Height	Current Weight
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### Women Only

Do you use any contraception?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If needed, please book appointment when registered Expected due date:
Are you currently pregnant or think you may be?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

### Repeat medications

We now use the Electronic Prescription Service (EPS) & your prescriptions will be sent electronically where possible to your nominated pharmacy. If you choose Parsonage Surgery, you will need to collect your prescription from the reception desk during working hours

**Please provide a *PRINTED* medication list to ensure there is no delay in medication being provided & book an appointment if required for a medication review.**

**\* WE WILL NOT ACCEPT HANDWRITTEN MEDICATION LIST'S**

### Please circle your preferred Pharmacy

Williamsons (Snowley Parade)	Trinity (T own Centre)	Hobbs (Hospital)	Boots Chemist	Lloyds (Thorley)	Yogi (Takeley)
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**Other Please specify Pharmacy and also add post code:**

**Patient Participation Group (PPG):**

You have been provided with a leaflet giving details of our PPG, would you like to attend meetings and/or receive updates via email. See our website for next meeting date.

**Attend PPG meetings:** Yes / No**Receive virtual PPG emails:** Yes / No**Online Access - SystmOnline**

You can book or cancel appointments, order repeat prescriptions view medications, allergies via Online Services called 'SystmOnline'

If you have consented to our SMS service we will text your log in details to you. If not we will provide these by letter.

**Contact details to be verified to allow use of Online Services:**

Please tick preferred method of communication for online service verification

Mobile number:

☐

Letter:

☐**Sharing Your Health Record****Third Party Consent**

If you wish a nominated person/s to be able to call us to discuss items related to your health, &/or if you prefer we call your nominated person/s instead of you, please complete & sign a 3<sup>rd</sup> party consent form. Without this document being completed we are unable to disclose **any** information regarding your health to a 3<sup>rd</sup> party i.e. family / carer etc.

Do you wish to nominate a 3<sup>rd</sup> party?

☐ Yes

No

☐**Your Summary Care Record**

Summary Care Records (SCR) are an electronic record of important patient information, created from GP medical records. They can be seen & used by authorised staff in other areas of the health & care system involved in a patient's direct care. For more information, please visit <https://www.digital.nhs.uk/summary-care-records/patients> / call NHS Digital on 0300 303 5678 or see leaflet provided to you / our website.

**Do you consent to having an Enhanced Summary Care Record with Additional information?**

☐ Yes (*recommended option*)

No

☐**Patient Charter**

Please sign & date below to confirm that you have read & agree to act within the Patient Charter displayed at the reception desk & provided to you within this registration pack.

**Did not attend policy (DNA)**

Please sign & date below to confirm that you have read & agreed to our DNA policy & provided to you within this registration pack.

Signature

Date

**RECEPTION TEAM ONLY – Please tick & pass forms to Registration Administrator**

Photographic ID seen: ☐  
(Photocopy documentation if required)

Proof of address seen: ☐

If born outside the UK is patient eligible for  
NHS care & is date entered UK completed: ☐

Alcohol screening form completed: ☐

Consent to PPG: ☐

Prescription list attached: ☐

GMS1 form checked & fully completed: ☐

Within catchment area? Postcode run through postcode checker on Parsonage Surgery website: ☐

Contact details verified by Registration Administrator ☐ 3<sup>rd</sup> party consent form completed – Yes / No

If Carer- Has the patient been offered carers in Herts referral form/passport

**Completed by .....** (Staff member name) **Date:**

**Notes:**