**LITTLE BUSHEY SURGERY**

**REGISTRATION FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| *Forename* | | *Surname* | |
| *NHS Number* | | *Previous Surname*  *(if applicable)* | |
| *Present Address (including post code)* | | | |
| *Home*  *Telephone* | *Work*  *Telephone* | | *Mobile*  *Telephone* |
| *Date of Birth* | *Sex* | | *Marital Status* |
| *Country of Birth* | *First Language* | | *Do you require an interpreter?* |
| *Are you a Carer?* | | *If you are a Carer, who do you care for, and what is your relationship?* | |

*Ethnic Origin (please tick)*

|  |  |  |
| --- | --- | --- |
| *British*  *Irish*  *Other White*  *White & Black Caribbean*  *White & Black African*  *White & Asian* | *Other mixed*  *Indian*  *Pakistani*  *Bangladeshi*  *Other Asian*  *Caribbean* | *African*  *Other Black*  *Chinese*  *Other group (please state)* |

***Medical History*** *Please provide information regarding your general health*

|  |  |
| --- | --- |
| *What is your height (cm) ?* | *Blood Pressure reading (from machine in reception)*  *……./………* |
| *What is your weigh (kg)t?* |
| *What are your smoking habits?*  *Never Smoked*  *Ex-smoker*  *Current Smoker*  *If current or ex-smoker, how many cigarettes do you/did you smoke a day?*  ***There is a smoking cessation clinic available at the surgery*** | *How much do you drink?*  *(per week)*  *Please complete alcohol questionnaire* |
| *What is your occupation?* | |
| *How much exercise do you take a week?* | |
| *Do you suffer from any allergies or intolerances? (please give details)* | |

**Do you need any specific communication support or need information in any particular format**

**Yes**  (if yes, please provide details\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) **No** 

*Please provide details of any regular medication being taken use a separate sheet if necessary)*

|  |  |  |
| --- | --- | --- |
| ***Name*** | ***Dosage*** | ***Frequency*** |
|  |  |  |
|  |  |  |
|  |  |  |
| *If you have a repeat prescription slip please supply it* |  |  |

*Please provide details of any serious illnesses, disabilities or operations. (Please list the most recent first, using a separate sheet if necessary)*

|  |  |
| --- | --- |
| *Date* | *Details* |
|  |  |
|  |  |

*Is there any* ***family history*** *of any of the following, if yes, please state relation**and age …*

*Cancer* …………………………………………………………………………………………..

*Diabetes* …………………………………………………………………………………………..

*High Blood Pressure* 

*Asthma* …………………………………………………………………………………………..

*TIA/Stroke* …………………………………………………………………………………………..

*Ischaemic Heart Disease*  *Over 60 yrs* *Under 60 yrs* 

*Other conditions?* …………………………………………………………………………………………………………………

***Additional details for Female Patients only***

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| --- |
| *Date of last smear test, and result \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

**Summary care record**

*The NHS uses an electronic record called the Summary Care Record (SCR) to support patient care.*

*The Summary Care Record is a copy of key information from your GP record. It provides authorised care professionals with faster, secure access to essential information about you when you need care.*

*The summary care record contains your details of your current medication, allergies and adverse reactions This is shared nationally with those medical staff who have a legitimate reason to look at your record with your permission.*

*If you wish to have a summary care record you do not need to do anything as this will happen automatically and be created from your GP record.*

*If you* ***do not*** *wish to have a summary care record then please complete the attached form to opt out of Summary Care Records. This can be done at any time. If you would like further information on the summary care record please ask at reception or visit* [*www.nhscarerecords.nhs.uk*](http://www.nhscarerecords.nhs.uk)

**Research & Planning -National Data Service**

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| To find out more about data sharing and how to set a national data opt-out please visit the ‘Your Data Matters’ website ([www.nhs.uk/your-nhs-data-matters](http://www.nhs.uk/your-nhs-data-matters)) or call 0300 303 5678 |

***SMS Messaging***

*The surgery uses SMS text messages to send you appointment and review reminders. Text messages will be sent to the mobile number provided at the time of registration.*

*I agree to take responsibility to keep the surgery informed of any changes to my contact details* 

*If you* ***do not*** *wish to receive SMS text messages from the surgery please tick this box*  ***Opt Out of SMS***



*the mobile number provided at registration. If this number changes, it is your responsibility to inform the surgery*

*Signed ……………………………………………..………………………………. Date ……………………………………………………………..*

***This form should be completed and handed to reception when registering at the practice.***

***You should also bring with you two forms of identification; one should contain a photograph (such as a passport, photo driving licence or for a child a birth certificate) and the other should provide address confirmation (such as a recent utility bill or a bank statement).***

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| --- |
| Office use only:  Photo ID seen Proof of address seen:  SMS Consent Documented Informing patients of named accountable GP  Parental Responsibility documented  Online Access Provided  Online Access Declined  New Patient Health Check offered  Registration form checked by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |









