

## THE NEAMAN PRACTICE

### New Patient Registration Form (Adult: 16 and over)

Complete EVERY SECTION in **BLOCK CAPITALS** (Use a separate form for each family member)

<b>*Title:</b>	<b>*First Name:</b>	<b>*Surname:</b>	
<b>*Date of Birth:</b>	<b>Marital Status:</b>	<b>*Gender:</b> M / F	
<b>*Ethnicity:</b>	<b>*Main Language:</b>		
<b>Sexual Orientation:</b>	Heterosexual <input type="checkbox"/> Homosexual/lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Prefer not to disclose <input type="checkbox"/> Other (please specify): -----		
<b>Occupation:</b>	<b>If returning from the Armed Forces please state which:</b>		
<b>*Mobile Number:</b>			
<b>*Home Telephone Number:</b>			
I do not wish to receive appointment reminders and health promotions (Tick here) <input type="checkbox"/>			
<b>*E-mail address:</b>			
How would you prefer us to contact you: SMS (text) <input type="checkbox"/>			
Phone <input type="checkbox"/> (The Practice recommends SMS (text) to allow rapid communication about health issues)			
<b>*Next of Kin:</b> (Name / Relationship / Contact Number)			
Is your next of kin registered with us? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>*Your Town* and Country of birth</b>			
Country:			
Town: <span style="float: right;">(*If town is London please state which Borough)</span>			

<b>CARERS</b>	
<i>(Please let us know if you are somebody's carer. We try to keep a record of our patients who are carers, and this helps us make sure we are looking after your health and wellbeing. It can help us to direct you towards the support you might need. This can make all the difference.)</i>	
<b>Are you looking after someone?</b> This could be someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems.	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Is someone looking after you?</b> Let us know if a family member, friend or neighbour looks after you. You are welcome to invite your carer to visits at the practice.	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Carer's Name / Address and Contact Number:</b>	
Is your carer registered with us? Yes <input type="checkbox"/> No <input type="checkbox"/>	

## MEDICAL HISTORY

<b>PAST MEDICAL HISTORY:</b>
Please state any allergies and sensitivities you have to medicines, food & dressings:
I have no allergies <input type="checkbox"/>
What chronic medical conditions have you had? Please give date of diagnosis:
I have no chronic medical conditions <input type="checkbox"/>
What operations or serious injuries have you had? (Please give details below)
Please list any tablets, medicines or other treatments you are currently taking / undertaking:
I am on no medication <input type="checkbox"/>

<b>OTHER INFORMATION</b>			
<b>Do you need help with mobility/hearing/speaking?</b> (tick all that apply)			
Wheelchair <input type="checkbox"/>	Walking Aid <input type="checkbox"/>	Hearing aid <input type="checkbox"/>	Lip reading <input type="checkbox"/>
Large print <input type="checkbox"/>	Braille <input type="checkbox"/>	British OR Makaton Sign Language <input type="checkbox"/>	
Other (please state) <input type="checkbox"/>		<b>Are you an 'Assistance Dog' User?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	

## SCREENING

<b>*Current Height (Metres or Feet):</b>	<b>*Current Weight (KG or Stones):</b>	<b>*Blood Pressure &amp; Pulse Reading:</b>
<b>*TB Screening</b>		
Have you lived in Africa/Asia in the last 5 years? <input type="checkbox"/>		
If so, you are eligible for a TB blood test. Please tick if you would like this YES <input type="checkbox"/> No <input type="checkbox"/>		
<b>*Sexual Health Screening</b>		

**\*HIV Testing**  
All new registered adult patients in City & Hackney are offered a HIV test. Is this something you would like us to contact you about? YES  NO

**\*Chlamydia Screening (15-24 year olds)**  
All newly registered patients in City & Hackney aged 15-24 years old are offered a free chlamydia test. Is this something you would like us to contact you about? YES  NO

## LIFESTYLE

<b>*Smoking Status:</b>	NEVER SMOKED <input type="checkbox"/>	CURRENT SMOKER <input type="checkbox"/> ____ DAILY/WEEKLY	EX-SMOKER <input type="checkbox"/>
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*We offer stop smoking service in the practice, please ask reception if interested*

**\*Alcohol Intake:** 1 unit = 1 small glass of wine, single measure of spirits OR ½ a pint of beer

**Units per week:**

Alcohol Audit-C Questionnaire:	Scoring System: (Please Circle)				
How often do you have a drink containing alcohol?	Never	Monthly Or Less	2-4 Per Month	2-3 Per Week	4+ 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 in the last year have you had 6 or more units if female or 8+ if male?	Never	Less Than Monthly	Monthly	Weekly	Daily or Almost Daily

### \*DIET AND EXERCISE

Balanced Diet <input type="checkbox"/>	Unhealthy Diet <input type="checkbox"/>		
No Exercise <input type="checkbox"/>	Gentle Exercise <input type="checkbox"/>	Moderate Exercise <input type="checkbox"/>	Vigorous Exercise <input type="checkbox"/>

## CONSENT, ONLINE SERVICES & PPG

### SHARING YOUR MEDICAL RECORD

**Local Record Sharing** allows your complete GP medical record to be made available to authorised local healthcare professionals involved in your care. You will always be asked your permission before anybody looks at your shared local medical record.

**If you don't want to share your GP record locally tick here:**

**Summary Care Record** contains details of your key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. Permission will always be asked before anybody looks at your SCR.

**If you don't want to have a Summary Care Record tick here:**

**The Care Data Programme** Collates information about you and the care you receive. It links information from all the different places where you receive care, such as your GP, hospital and community services, to

help them provide a full picture of your medical needs and the care you are receiving. This data is made available to NHS Commissioners so that they can design integrated services and is shared with third parties for research purposes.

**OPT OUT of my Personal Confidential Data being shared with third parties (Non Healthcare Professionals)**

### GDPR – Patient and Practice Data Sharing Agreement

I read and understood the GDPR data sharing information attached to this registration form.

**Agree to Data Sharing terms and conditions**  **Decline to Data Sharing terms and conditions**

### ONLINE SERVICES

You can now do the following online or via the NHS app: book and cancel appointments, order repeat prescriptions, view your medical record and access a range of other healthcare services.

*It is your responsibility to keep your login details and password safe and secure. If you suspect your record has been accessed by someone change your password immediately.*

**The NHS App is free to download from the App Store and Google Play**

### PATIENT PARTICIPATION GROUP (PPG)

The Practice is committed to improving the services we provide to our patients. It is vital that we hear from people about their experiences, views, and ideas for making services better by expressing your interest, you will be helping us to plan ways of involving patients that suit you. We will keep you informed of opportunities to give your views and up to date with developments within the Practice. If you are interested in getting involved in the PPG please indicate below and we will arrange for the Practice Patient Participation Group to contact you.

I AM **INTERESTED** in joining the PPG

I AM **NOT INTERESTED** in joining the PPG

Scan and save Practice Contact to your Phone

Scan to access Practice Website



### SIGNATURE

Patient signature & Date:

OR Signature on behalf of patient:

**Thank you for completing this form.**