# Grafton Road Surgery

# New Patient Registration

## Your Details

Please complete and return this questionnaire together with **2** forms of identification.

- Passport or photo driving licence or National Identity Card.
- Bank/Building Society statement or utility bill (less than 3 months old) showing home address.

**Have you been registered with this surgery in the past? Yes ☐ No ☐**

**If yes, when? ……..**

**Your Nominated/Allocated GP is your Registered GP**

| | |
|---|---|
| **NHS Number** **(Available from Previous Surgery)** | |
| **Title** **(Mr, Mrs, Mis, Miss etc)** | |
| **Surname** | |
| **First Name** | |
| **Date of Birth** | |
| **Address Line 1** | |
| **Address Line 2** | |
| **Address Line 3** | |
| **Post Code** | |
| **Email Address** | |

| | |
|---|---|
| **Home Telephone No.** | |
| **Mobile Telephone No.** | |

## Previous Details

**Please help us trace your previous medical records by providing the following information:**

| | |
|---|---|
| **Previous Doctor** | |
| **Previous Surgery Name** | |
| **Address** | |

## Your Previous Address

| | |
|---|---|
| **Address Line 1** | |
| **Address Line 2** | |
| **Address Line 3** | |
| **Post Code** | |

## If you are from Abroad

| | |
|---|---|
| **Place of Birth** | |
| **Date you arrived in UK** | |

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**Ethnicity**
**(Please circle as appropriate)**

| White | Mixed | Black | Asian | Chinese |
|---|---|---|---|---|
| White British<br>White Irish<br>White European | White / Black Caribbean<br>White / Black African<br>White / Asian | Black British<br>Black Caribbean<br>Black African<br>Other Black background | Indian<br>Pakistani<br>Bangladeshi<br>Other Asian Background | |
| | Any other ethnic category ; please state | | | |

| | |
|---|---|
| **Main Language Spoken** | |

**Next of Kin**

| | |
|---|---|
| **Name** | |
| **Relationship** | |
| **Contact Details** | |

**Smoking Habits**

**Please tick the appropriate box**

| Smoker | Never smoked | Ex-smoker |
|---|---|---|

**If you are a Smoker please answer the following :**

**What do you smoke?**
**(Please circle)**

| Cigarettes | Cigars | Pipe | Electronic Cigarettes |
|---|---|---|---|

**How many Cigarettes to you Smoke :**

| 1 – 10 per day | 10 – 20 per day | 20 + per day |
|---|---|---|

**If you would like Help to Quit Smoking, please ask for details at Reception**

**Healthcheck**

We offer a New Patient Health Check to newly registered patients, if you would like to have one, please speak with a Receptionist.

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## Family History

Has any close family member (grandparent, parent, brother, sister, aunt or uncle) had any of, or suffer from, any of the following?

| Problem | Their Relationship To You | Their Age when Diagnosed |
|---|---|---|
| **Heart Attack** | | |
| **Angina** | | |
| **Stroke** | | |
| **Asthma** | | |
| **Diabetes** | | |
| **Cancer** **(State type, eg. bowel, breast)** | | |

## Alcohol Habits

One alcohol unit equals one 25ml single measure of whisky (ABV 40%), or a third of a pint of beer (ABV 5-6%) or half a standard (175ml) glass of red wine (ABV 12%).

**Please complete the following by circling the appropriate answer:**

| | |
|---|---|
| **Do you drink alcohol?** | **Yes / No** |

| | |
|---|---|
| **Estimated Units Per Week** | |

**How often do you have 8 (Men) 6 (Women) or more drinks on one occasion?**

| | | | | | |
|---|---|---|---|---|---|
| Never | Less than Monthly | Monthly | Weekly | Daily | Almost Daily |

**How often during the last year have you been unable to remember what happened the night before because you had been drinking?**

| | | | | | |
|---|---|---|---|---|---|
| Never | Less than Monthly | Monthly | Weekly | Daily | Almost Daily |

**How often during the last year have you failed to do what was normally expected of you because of drinking?**

| | | | | | |
|---|---|---|---|---|---|
| Never | Less than Monthly | Monthly | Weekly | Daily | Almost Daily |

**In the last year has a relative or friend, or doctor or other health worker been concerned about your drinking or suggested that you cut down?**

| | | |
|---|---|---|
| No | Yes | At least one occasion |

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## Current Medication

Please give details of any medication which you take (prescribed or otherwise):

| Name of Drug | Dosage |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

| | |
|---|---|
| **Would you like to nominate a Pharmacy for prescriptions?**<br><br>**If Yes all future prescriptions will be sent electronically to your nominated pharmacy** | **Yes / No** |
| **Pharmacy Name and address:** | |

## Past Medical History

| |
|---|
| **Please give details of any previous significant past medical history :** |

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**Carers**

**Do you have a Carer? Yes / No**

**If YES** please provide their details :

| | |
|---|---|
| Name | |
| Address | |
| Telephone No | |

**Are you a Carer ?**

Do you look after someone who is ill, frail, disabled or mentally ill?

| | |
|---|---|
| Name | |
| Address | |
| Telephone No | |

**Armed Forces**

| | |
|---|---|
| Are you an Armed Forces Veteran ? | **YES / NO** |
| If YES, which Service? | |

| | |
|---|---|
| Are you currently employed by the Armed Forces? | **YES / NO** |
| If YES, which Service? | |

**Data Sharing**

**You need to let us know if you wish to opt out of any of the services below :**

**Summary Care Record**

A Summary Care Record is an electronic record which contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you have had.

Having this information stored in one place makes it easier for other healthcare staff to treat you in an emergency, or when your GP Practice is closed.

| | |
|---|---|
| **YES** - **I DO** wish to have my Summary Care shared with other Healthcare Professionals | |
| **NO** - **I DO NOT** want my Summary Care Record shared with other Healthcare Professionals | |

| | |
|---|---|
| **Signature of Patient** | |

| | |
|---|---|
| **Name and Signature on Behalf of Patient** | |
| | |

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## New Patient Registration

**Your Care Connected**

This is a more detailed record that can be shared with local hospitals and community services throughout Solihull, Birmingham and Sandwell. This enables all organisations to share important details of your medical history along with investigations, test results, medication etc.

The aim is to improve communication across local GP's, hospitals and community services and helps avoid duplicating investigations such as blood tests.

| | |
|---|---|
| **I wish to OPT OUT of Your Care Connected** | |

| | |
|---|---|
| **Signature of Patient** | |

| | |
|---|---|
| **Name and Signature of Behalf of Patient** | |

**Consent for Communications**

| | | | |
|---|---|---|---|
| **I consent to receiving Text messages for appointments, reminders etc** | **Yes / No** | **Date** | |
| **I consent to receiving Email Messages for appointments, reminders etc** | | | |

**Accessibility**

**We aim to ensure that all patients have access to services at the Practice. If you require accessibility support please detail below;**

| | |
|---|---|
| British Sign Language Interpreter | ☐ |
| Audible Alerts | ☐ |
| Large Print | ☐ |
| Accessing Test Results, Immunisations and Problems | ☐ |

| | |
|---|---|
| What is your preferred method of communication? | |
| How would you like us to communicate with you? | |
| What support would be helpful? | |
| What is the best way to send you information? | |

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## Access to GP Online Services Form

In order for Access to be given Identity **must** be verified, please provide one of the following for verification:

- Passport P
- Photo Driving Licence
- National Identity Card.

| | |
|---|---|
| **Surname** | |
| **First name** | |
| **Date of birth** | |
| **Address** | |
| **Postcode** | |
| **Email address** | |

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

| | |
|---|---|
| Booking appointments | ☐ |
| Requesting repeat prescriptions | ☐ |
| Accessing Test Results, Immunisations and Problems | ☐ |

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**For practice use only**

| | | | | |
|---|---|---|---|---|
| Identity Verified By: (Please Tick) | Vouching | | Photo ID | |

| | | | |
|---|---|---|---|
| Verified By | Name: | Signature: | Date |

| | |
|---|---|
| Scanned to Record By: | |
| Date scanned: | |
| Use Read Code | Xabui |