CLAREMONT BANK SURGERY
New Patient Registration Form

TEL: 01743 248244

Website: www.claremontbanksurgery.co.uk

Thank you for applying to join the list of Claremont Bank Surgery. Please let Reception know if you would like a copy of the Surgery Leaflet.

PREVIOUSLY REGISTERED WITH US? YES / NO

TITLE

MR ☐ **MRS** ☐ **MS** ☐ **MISS** ☐ **DR** ☐ **OTHER** ☐

Surname: ______________________________

First name: ____________________ **DATE OF BIRTH:** ____________________

Place of Birth: ______________________________

If the patient is under 16 please provide details of other members in the household below:

Name	Relationship to patient	Contact number

IMMIGRANTS: - What date did you arrive in the United Kingdom? ____________________

Have you ever served in the BRITISH ARMED FORCES? YES/NO

Dates of Joining ____________________ **Date of Leaving** ____________________

NEW/CURRENT ADDRESS:

PREVIOUS ADDRESS:

CONTACT DETAILS:

(Please only give us contact numbers that you would be happy for us to contact you on- no personal information will be disclosed on a messaging service.)

Email: ***(Essential to be provided with an online access account)**

Mobile:

Home: **Work:**

NAME OF PREVIOUS GP: **GP ADDRESS:**	**YOUR NAMED ACCOUNTABLE GP IS:** **Dr Bailey** **You can still see all the other Doctors in the surgery. If you would like to specifically nominate a GP please tell the receptionist.**

- Would you like to receive emails with our Monthly Newsletter? **YES / NO**
- Would you like information on how to join our Patient Participation Group? **YES / NO**
- Would you like to receive the text message appointment confirmation and reminder service? **YES / NO**

Patient Access Online Account Information:

We now set up online access accounts for all new registering patients. Please note you must have provided us with an individual email address on the previous page.

If you would NOT like an online access account please tick this box ☐

You will receive your patient access registration details and instructions on how to register from us via the email address you have provided within 1 -2 working days after we receive your registration form. You will be given access to 'Ordering Repeat Medications' and 'Appointment Booking' as standard.
If you would like to find out about 'Proxy' access (which will allow you to look after the account of someone you care for) or, if you need further access to your medical record, please enquire at Reception.

Important considerations for having a patient access online account

- Forgotten history: there may be some things in your record you have forgotten.
- Choosing to share your information with someone: It's up to you but also your choice to keep the information safe and secure.
- Misunderstood information: your medical record is designed to be used by clinical professionals. If you require clarification please contact the surgery.
- Information about someone else: If you spot something in the record that is not about you please log out immediately and contact the practice.

It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your records have been accessed by someone without your consent then you should change your password immediately or contact the practice. If you choose to print any information from your record it will also be your responsibility to keep it secure.

Please sign to acknowledge and accept responsibility to keep your sensitive information secure:

Emergency Contact Details:

Full name:

Contact number:

Relationship to patient:

- **Do you have a 'Living Will' (also known as an Advance Decision) explaining the medical treatment you want in the future?**

YES/NO

If YES, please bring a copy of this to your New Patient Health Check.

- **Have you nominated someone to speak on your behalf (Power of Attorney)?**

YES/NO

If YES, please provide their details in the space below and return a copy of the certificate with this completed form.

Full name:

Contact number:

Relationship to patient:

- **Do you look after someone? Please provide their details below.**

Full name:

Address:

Postcode:

Contact number:

- **Does someone look after you? Please provide their details below.**

Full name:

Address:

Postcode:

Contact number:

- **Would you like more information on the kinds of support Becky, our Community Care Coordinator could offer you?** *A Community and Care Co-ordinator is based in your local GP practice. They assist patients in need of help, support and advice by signposting them to other useful services. Community and Care Co-ordinators work with the NHS, the Council and voluntary services and have become local experts on what's happening in your community. They can help you to keep socially active and maintain your independence.*

YES/NO

If YES, Becky will be in touch for an informal discussion.

Ethnic Origin

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E, and then tick ONE box to indicate your background.

A White

	British
	Irish
	Any other white background, please state:

B Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background, please state:

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background, please state:

D Black or Black British

	Caribbean
	African
	Any other black background, please state:

E Chinese or other ethnic group

	Chinese
	Any other, please state:

First language spoken:

- **Do you require a translator?**

YES/NO

If YES, please tell us which language you speak: ______________________________

Communication Requirements

- **Would you like us to contact you in a certain way? (For example, large print documents, British Sign Language interpreter, easy read braille etc.)**

YES/NO

If NO please go straight to Medical Information on page 7.

Please inform the surgery team if your needs change in the future.

- **Do you consent for us to share your communication needs with other healthcare providers if required?**

YES/NO

Communication Requirements

Providers of health and adult social care services have new duties to support those who access their services who have sensory impairments and/or learning disabilities. They must:

1. **Identify** the communication and information needs of those who use their service;
2. **Record** the communication and information needs they have identified;
3. Have a consistent **flagging** system so that if a member of staff opens the individual's record it is immediately brought to their attention if the person has a communication or information need;
4. **Share** the identified information and communication needs of the individual when appropriate;
5. **Meet** the communication and information needs identified.

In accordance with The Accessible Information Standard (SCCI 1605 (Accessible Information)) please accept the below as formal notification of my information and communication preferences.

I communicate using (e.g. BSL, deafblind manual):

To help me communicate I use (e.g. a talking mat, hearing aids):

I need information in (e.g. braille, easy read):

If you need to contact me the best way is (e.g. email, telephone, text):

Medical Information

PAST MEDICAL HISTORY (IF ANY):

CURRENT MEDICATIONS

	YES / NO	COMMENT
DIABETIC		
ASTHMA		
DEPRESSION		
HIGH BLOOD PRESSURE		
ARE YOU INTERESTED IN CHANGING YOUR LIFESTYLE E.G. STOPPING SMOKING OR LOSING WEIGHT?		**If YES, our advisor Annemarie will be in touch to see if you may be suitable for a Health Coaching session here at the surgery. Health Coaching can help you to set realistic goals and an action plan to achieve them.**

Please nominate a pharmacy for your prescriptions to be sent to ELECTRONICALLY:

Name of Pharmacy:

Location & Post code:

Summary Care Record

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have a choice

You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

☐ **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only.

☐ **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

☐ **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

If you chose not to complete this consent form, a core Summary Care Record (SCR) will be created for you, which will contain only medications, allergies and adverse reactions.

You are free to change your decision at any time by informing your GP practice.

Summary Care Record patient consent form

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP practice:

Yes – I would like a Summary Care Record

☐ Express consent for medication, allergies and adverse reactions only.

or

☐ Express consent for medication, allergies, adverse reactions and additional information.

☐ **No – I would not like a Summary Care Record (**Express dissent for a Summary Care Record – **OPT OUT.)**

Please Complete:

Name of patient: …………………………………………………………………………

Date of birth: …………………………… Patient's postcode: …………………

Surgery name: …………………………… Surgery location (Town): ………………………

NHS number (if known): ……………………………………………………………………………

Signature: ……………………………. Date: ………………………………

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: …………………………………………………………………………………………………

Please circle one: Parent Legal Guardian Lasting power of attorney

Please now return this form to Reception, along with:

For those aged 18 and over: two forms of ID (eg. Driving Licence/Passport/Utility Bill) to Reception. For those aged 16 and over: one form of photo ID (eg. Passport/Student ID) or Birth Certificate.

Office use only

Code as 'patient signed registration form'.

- ☐ Please tick to confirm ID has been provided and verified
- ☐ Please tick to confirm Summary Care Record preference has been completed
- ☐ Please tick to confirm that if the patient has not opted out of having an online access account and that they have signed to acknowledge responsibility for keeping their sensitive information secure.