Forest Hill Road Group Practice
1 Forest Hill Road, London, SE22 0SQ
Telephone: 020 8299 1234
Fax: 020 8299 5699

June 2018

New Patient Registration Pack

(Please retain the first 2 pages for your information)

Initial information for NEW Patient Registration

A. To register with this surgery, all new patients are required to complete –

1. NHS Registration Form (GMS1-Purple form) **and**
2. New Patient Registration form

B. In support of the registration process a valid

- **Passport**
- **Citizenship ID**
- **Resident Permit ID Card**
- **Birth Certificate (for new born babies)**

is required for proof of your Identity. Ω

C. Please provide 2 proofs of your home address in your name**. Please ensure that the 2 proofs of address are from the following:

1. Utility Bill (i.e. Electric, Gas or BT) with a date within the last 3 months
2. Bank Statement with a date within the last 3 months
3. Tenancy Agreement with a minimum of 6 months duration on contract
4. Council Tax Bill
5. UK Drivers' License

Ω **In exceptional cases a valid UK Driver's License or Birth Certificate may be accepted**

** **Husband/ Parent proof of addresses covers** Spouses/ young children

Did Not Attend Policy

PLEASE KEEP THIS PAGE FOR YOUR REFERENCE TO OUR DNA POLICY

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Approximately 220 *appointments* per month are 'Did Not Attend' (DNA), i.e. the patient does not turn up for the appointment and do not contact the surgery in advance to cancel/change appointment. The effects of these are:

- An increase in the waiting time for appointments
- Frustration for both staff and patients
- A waste of resources

If a patient fails to attend a pre-booked appointment a 1st DNA letter/text message will be sent to the patient, advising them that a further occurrence could risk removal from the Practice. (See Appendix I)

If the patient fails to attend another (2nd) appointment within a 12 month period of the 1st DNA, a 2nd DNA letter/text message will be sent to the patient advising them that a further occurrence could risk removal from the Practice.

If the patient fails to attend another (3rd) appointment within a six month period a removal letter will be sent to the patient to inform the practice intention to begin the deduction process. The patient can request for repeat prescriptions during the deduction process and the practice also advice patients to register with another practice. The removal of a patient from our register may take up to 28 days.

Any patient who has failed to attend more than 4 appointments in a space of the last 365 days will be sent removal notice with no prior warning.

New Patients

All newly registered patients **must** attend a new patient medical with our Health Care Assistant, if the patient DNA's this appointment they will be automatically removed from the practice list.

PLEASE COMPLETE ALL SECTIONS OF FORM IF RELEVANT TO YOU

If ***English is your second language*** and you are having difficulties completing this form, please ***seek help from your children or community***. The practicing encourages patients who English is their second language to ***enrol with the local Adult Education Centres***. Please ask at reception for information.

IMPORTANT NOTE:

The Practice Staff will only accept forms which are completed fully with relevant supporting documents. ***Your form may be given back to you if it is not fully completed or if presented without the correct documentation.***

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Date:.....

NEW PATIENT REGISTRATION FORM

Staff Receiving Documents:

Title: ..... **Surname:** ..... **First name:** .....

Address: ..... **Date of Birth:** .....

.....**Postcode:** ..... **Marital Status:** .....

Gender: ..... **Occupation:** .....**Tel(Hm)** ..... **(Wk)** .....**(Mob)** .....

ETHNIC MONITORING: *(Please indicate your ethnicity by ticking the relevant box below:*

White
- ☐ British
- ☐ Irish
- ☐ Other White Background

Black or Black British
- ☐ African
- ☐ Caribbean
- ☐ Other Black Background

Asian or British Asian
- ☐ Bangladeshi
- ☐ Indian
- ☐ Pakistani
- ☐ White & Asian
- ☐ Other Asian Background

Mixed
- ☐ White & Black African
- ☐ White & Black Caribbean
- ☐ Other Mixed Background

Other
- ☐ Chinese
- ☐ Declined to State
- ☐ Other White Background

Borough: .....
.(i.e. Hillingdon)

Main spoken language *(Please specify)* ..... **.Level of Spoken English:** ....

Interpreter Required [(*Please tick* (√)]: Yes ☐ No.☐ *(If English is second language)*

NEXT OF KIN: Name: ..... **Relation:** .....

Address: .....

..... **Postcode:** ..... **Telephone No:** .....

ALCOHOL

How often do you have a drink containing alcohol?
ONE UNIT: (half pint of ordinary strength lager/beer, cider (3.5% abv) PR a 25ml pub measure of spirits (40% abv OR a small glass of wine (9% abv, many wines are 11% or 12 % abv)

How often do you have a drink containing alcohol? *Please tick (√) appropriate answer below*

Never	(0)	Monthly or less	(1)	2–4 times a month	(2)	2–3 times a week	(3)	4 or more times a week	(4)

How many unites of alcohol do you have on a typical day when you are drinking?

1 or 2	(0)	3 or 4	(1)	5 or 6	(2)	7 - 9	(3)	10 or more	(4)

How often do you have 6 or more standard drinks on one occasion?

Never	(0)	Less than monthly	(1)	Monthly	(2)	Weekly	(3)	Daily or Almost Daily	(4)

Cigarettes : ☐_____ per day How Many Years Have you smoked *(Please specify)* _____ years

☐ None ☐Quite date _____ ☐ Never smoked

ALLERGIES: No Known Allergies☐ Medication_____ Hay Fever _____

❖Food Allergy_____ Animal _____ OTHER: _____❖

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HEIGHT & WEIGHT: Weight _____ Kg Height _____ cm

Exercise: Type: _____ minutes/day _____ days/week _____

Vaccinations: _____ _____ _____
(Children registration) **Parents are to provide Children's immunisation records.**

Would you like to have a Test for [(*Please tick* (√)] : HIV☐ **Chlamydia**☐ **Hepatitis B ,C** ☐

Current Medications: _____ _____

_____ _____

Family History

Does any member of your family have problems with..? ***(Please specify family member)***

☐ Diabetes _____ ☐ Heart disease _____ ☐ High blood pressure _____

☐ Asthma _____ ☐ High cholesterol _____ ☐ Stroke/circulation _____

☐ Thyroid _____ ☐ Cancer _____ ☐ Depression / psychiatric probs_____

FEMALE PATIENTS

Have you had a cervical smear (pap test)? Yes ☐ No ☐ **IF Yes,** give date of test. _____
Was the result normal? Yes ☐ No ☐
Have you ever had an abnormal smear Yes ☐ No ☐
Was it done at your GP surgery in the UK? Yes ☐ No ☐
If No, where was it carried out? _____
Length of Monthly Cycle: _____
Number of Pregnancies: _____ Contraception: _____

Operation / Hospital Procedures

_____

General medical concerns

Cardiovascular (heart, arteries, veins)

Hypertension ☐
Heart murmur ☐
Heart attack ☐
Valve problems ☐
Varicose veins ☐
Stroke ☐
Other: _____

Gastrointestinal (stomach, liver gall bladder & intestines)

Hypertension ☐
Heart murmur ☐
Heart attack ☐
Valve problems ☐
Varicose veins ☐
Stroke ☐
Other: _____

Respiratory (lungs)

Asthma ☐
Emphysema ☐
Tuberculosis ☐
Other: _____

Neurological (brain & nerves)

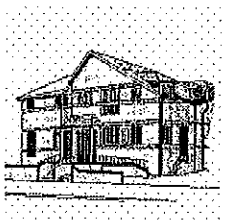
Migraines ☐
Epilepsy ☐
Sleep problems ☐
Other: _____

Eye

Cataracts ☐
Glaucoma ☐
Other: _____

Psychiatry

Neurosis ☐
Depression ☐
Schizophrenia ☐
Other: _____



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Genitourinary (kidney, bladder)
Kidney stones ☐
Other: _____

Men only
Enlarged prostrate ☐

Women Only
Fibroid tumor ☐
Pelvic inflammatory disease ☐

Endocrine (hormones)
Diabetes ☐
Thyroid ☐
Other: _____

Haematology (blood, cancer)
Bleeding problem ☐
Cancer ☐
If yes, please specify where;_____
Other: _____

Musculoskeletal (muscles & bones)
Arthritis ☐
Back problem ☐
Hip/knee replacement ☐
Bone fracture ☐
Other: _____

Other problems

_____

For Practice use

Height: _____ **Weight:** _____ **Blood Pressure:** _____ **Pulse:** _____

Waist Cir: _____ **Urine:** _____

(Please continue overleaf)

To: **All Existing and NEW Patients**

A: **RE** SUMMARY CARE RECORD (***MUST BE COMPLETED)***

The practice requires your consent for sharing your data with other healthcare and medical service providers in the UK. Please select **ONE** option below to indicate the level of information you prefer to be shared:

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

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

3. ☐ Express dissent (opt out) – Patient does not want a Summary Care Record
*(**Please note** in an emergency the medical service providers will be unable to view YOUR information indicated in 1 & 7 above)*

Patient Name: _____ **D.O.B.** _____

Address: _____

Postcode: _____ **Signature of Patient:** _____ **Date:** _____

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B: RE: ELECTRONIC PRESCRIBING SYSTEM

This system enables the surgery to send ISSUED prescription requests electronically to patients' nominated chemists for dispensing. If interested please provide the relevant details below:

What are the Benefits of EPS?

1. Patients do not need to collect issued prescriptions from Practice
2. Prescription is sent electronically to your nominated chemist
3. Help speeds up the issue and dispensing of prescribed medications.

Name of Chemist: _____ **Contact No:** _____

Address: _____ Postcode: _____

C: RE: PATIENT Online Service

New patients *are unable to use the services below until their registration is approved by the health authority and you get included to our practice list which can take approximately 2 to 3 weeks or longer.*

The Patient Online Services provides **24/7** access to the following services provided by the Practice:

- Ability to request for **Repeat Prescription (but not Acute Medication);**
- Ability to book **Appointments;**
- Ability to view **some information on your medical records.**

To sign up for this service, please complete the attached form which will be processed after your registration has been confirmed via the NHS Registration Systems. You will be contacted by our Reception/Admin team to collect your Unique PIN number with information on how to register online to activate for the service..

Please note that by completing this application form for PATIENT ONLINE SERVICE you give your consent for your personal data to be used through NHS-approved confidential electronic media.

Please note that only the named patient (or parent/guardian if under 14) may collect the Access Registration letter. Please bring with you a form of Photo ID to collect the letter. This is to ensure that we give access to the right patient.

IMPORTANT NOTICE: It is necessary that you provide your current contact details should we need to contact you. If you prefer that a message is left on your current telephone number please tick this box: ☐

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Application for online access to my medical record

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number

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

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	☐

Signature	Date

For practice use only

Patient NHS number		Practice computer ID number
Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID and proof of residence ☐