

**PUDDLETOWN SURGERY**

**CONFIDENTIAL MEDICAL REGISTRATION FORM**

Do you have any Communication Needs? <i>Please tick box</i>		Yes	No
If yes, please tick: <input type="checkbox"/> British Sign Language <input type="checkbox"/> Braille <input type="checkbox"/> Large Print <input type="checkbox"/> Interpreter <input type="checkbox"/> Easy Read <input type="checkbox"/> Lip Reading <input type="checkbox"/> Speech to Text Reporter <input type="checkbox"/> Advocate			
If you need interpretation what is your first language?			
Full name		Home phone number	
Previous Surname		Work phone number	
Date of Birth		Mobile	
Address		Ethnicity:	
Email:		First language	

**Email and Text consent:**  
Please can you confirm that you are happy for Puddletown Surgery to contact you by the following:  
By email: Yes  No  This will be to send you a copy of our newsletter.

*I understand that my emails could be read and intercepted by a third party as emails are not secure.*

By text: Yes  No  This will be to send you reminders of your appointments.

*Text messages are generated using a secure facility however I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. Puddletown Surgery will not transmit any information which would enable an individual patient to be identified.*

**NEXT OF KIN - EMERGENCY CONTACT**

NAME	TELEPHONE NUMBER	RELATIONSHIP TO YOU

**Summary Care Record (SCR)**  
Your basic details are uploaded to the national NHS database and can be viewed by other health professionals in an emergency.

Please tick the box if you wish to opt out of the SCR    (9Ndo)

**Named GP:** all patients registered at Puddletown Surgery have a named GP to oversee their care. Your named GP will take responsibility for ensuring your care is provided by working with the practice team and other relevant health professionals to deliver care that meets your needs. You will initially be allocated a named GP as your 'usual GP'. You may then see whichever GP you want to and change your named GP if you wish.

## LIFESTYLE

Please enter your height and weight	Height:	Weight:
-------------------------------------	---------	---------

<b>Your Alcohol Usage</b>	Please <b>circle</b> the answer that applies				
How often you do have a drink that contains alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How many units of alcohol do you have on a typical day when you are drinking? See below	1-2	3-4	5-6	7-8	10+
How often do you have 6 or more units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Pint of regular beer/lager/cider = 2 units; can of lager = 1.5 units; 175ml glass of wine = 2 units; single glass of spirits = 1 unit; bottle of wine = 9 units.					

Current smoker <b>(circle)</b>	YES	NO	If yes: cigarettes, pipe or cigar?	Quantity/day?
Previous smoker?	YES	NO	If yes: type and quantity/day	When did you give up?
Would you like help to quit smoking? Yes <input type="checkbox"/> No <input type="checkbox"/>				

Do you exercise? Yes / No				
What exercise do you do?				
How often do you exercise, per week?	Not at all	1 time	2 times	3+ times

<b>Medication:</b> If you are taking medication please make an appointment to see a GP and bring your repeat prescription with you.
----------------------------------------------------------------------------------------------------------------------------------------

## DATA SHARING

If you wish to opt out of any data sharing please indicate below:	
I do not wish any identifiable data about me to leave the practice	<input type="checkbox"/> (9Nu0)

<b>Patient Reference Group:</b> The Practice is committed to improving the services we provide to our patients. To do this it is vital that we hear from people about their own experiences, views or ideas for making services better. At times we request feedback from patients as well as send out information about local health services. You do not need to respond but it does help us to develop our services for you. If you are happy for Puddletown Surgery to contact you please tick the box <input type="checkbox"/>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

I confirm that the information I have provided is true to the best of my knowledge.	
Signed:	Date:

## PERSONAL MEDICAL HISTORY

Have you ever suffered from any important medical illness, operation or admission to hospital?  
If yes please enter the details below:

Condition	Year diagnosed	Ongoing
		Yes / No
		Yes / No
		Yes / No
		Yes / No

Have any close relatives (*father, mother, sister or brother only*) ever suffered from any of the following and at what age? Please indicate who in the boxes below:

Heart attack	Stroke	Diabetes	High Blood pressure	Asthma	Glaucoma	Cancer

**Please list any allergies you have to any drugs/medication:**

Name of Medication	Symptoms

**Female patients only:**

Are you currently pregnant?	Yes / No
What method of contraception (if any) are you using at present?	
Patients aged 25 -64: When was your last cervical smear test?	

Have you ever served in the armed forces or are you part of the wider armed forces community (family, reservist etc.) Yes  No  if Yes which service.....

*(Admin codes: 13JY history relating to military service, 095 active duty military, 0950 Army, 0951 RAF, 0952 Navy and 0953 Marines)*

**Are you a carer?** Yes  No

If yes please tell us the name & address of the person you care for (please note that both parties will need to sign a consent form available at reception):

**Do you have a carer?** Yes  No

If yes please tell us the name & address of your carer (please note that both parties will need to sign a consent form available at reception):

**Are you happy for us to contact your carer about you?**

Yes  No

**FOR ADMIN USE ONLY**

<b>NAME:</b>	<b>NHS NO:</b>	<b>EMIS NO:</b>
<b>Process</b>	<b>INITIALS</b>	<b>Date</b>
<b>FRONT DESK:</b>  Patient registered on EMIS – If patient not found on the Spine then registration to be stopped and information checked <i>Put registration form in folder on Admin desk</i>		

<b>BACK DESK :</b>  NOK information added		
Data sharing consent choices added if patient has signed and chosen an option		
Patient reference group code to be added only if patient has opted OUT ( <b>9NSG</b> ) <i>N/A for children under 16</i>		
Email address added to the website for subscription to newsletter etc – <i>N/A for children under 16</i>		
Alcohol & Smoking status added – <i>N/A for children under 16</i>		
History of Armed Forces Coding		
Form scanned and workflowed		
If child under 5 please inform Health Visitor with a message in their book		

<b>FRONT DESK</b>		
When notes have arrived pull the registration form out, mark records as arrived on EMIS		
Blood /Organ donors – put form into folder on Admin desk		
Sticky note put on notes marked with <b>S&amp;T, Vikki, Lorna (only if female and over 25), GP2GP</b>		
Place in sorting and tagging box in date order		