The Mandeville Practice

New Patient Registration Form (Adult: 16 and over)

Instructions for completing this form

1. Complete a separate form for each family member to be registered
2. Complete in BLOCK CAPITALS and tick the boxes as appropriate

Personal Details	
Full Name:	**Date of Birth:**
Do you have a carer YES / NO - If yes, please give carer's details	
Title : ☐Mr ☐Mrs ☐Miss ☐Ms **Other.** *Please state* **:**	**Gender:** ☐Male ☐Female ☐Other. *Please state* **:** **Sexuality:** In the interest of your health care the answers to the following questions could be of benefit. The questions are however optional. These are the basic types of sexual orientations: Which one would be applicable to you? ☐Heterosexual ☐Bisexual ☐Lesbian ☐ Gay
Are you: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**	
What is your occupation?	
Mobile tel. number: We will use this to send appointment reminders and health promotion details. Please tick here to give your consent for this: ☐	**Maiden name / Mothers name if different:** **Current Address:** **Postcode:**
Work tel. number:	**E-mail address:**
Next of Kin: **Relationship to Patient:**	**Next of Kin contact tel. number:**
How would you prefer us to contact you: ☐ **Letter** ☐ **Email** ☐ **SMS (text)** ☐ **Phone**	
Town* and Country of birth **Country:** **Borough (*If born in London):** **(*If town is London please state which Borough)** **Town:**	

Please list other residents of your Home who are registered with us:	**Name:**	**Date of Birth:**

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Veteran Status: Have you ever served in the regular or reserve British Armed Forces? YES / NO
Did you serve in the: Royal Navy ☐ British Army ☐ Royal Air Force ☐ Royal Marines ☐
Service Number:

Looking After A Family Member	
Are you looking after someone? Let us know if you are looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems.	☐Yes ☐No
Is someone looking after you? Let us know if a family member, friend or neighbour looks after you. If yes, they are your carer. You are welcome to invite your carer to accompany you to visits at the practice.	☐Yes ☐No
Carer's name :	**Relationship to you:**
Address of carer :	
Telephone number of carer :	

Are You Currently Employed?			
If so please specify whether :	☐**Full-time**	☐**Part-time**	☐**Self-employed**
If you are not employed, please indicate which best describes you:			
☐ **Retired**	☐ **Student**	☐ **Housewife/ Homemaker/House husband**	☐ **Unemployed**
☐ **Other** ***Please state***:			

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Public Health Statistics						
Your Religion (Please tick)	C of E ☐	Catholic ☐	Other Christian ☐ (state):	Buddhist ☐	Hindu ☐	Muslim ☐
	Sikh ☐	Jewish ☐	Jehovah's Witness ☐	No religion ☐	Other religion ☐ (state)	
Your Ethnic Origin (Please tick one)	White (UK) ☐		White (Irish) ☐	White (Other) ☐		
Black Caribbean / British ☐	Indian / British Indian ☐		Arabic ☐	Other Mixed Background ☐		
Black African / British ☐	Pakistani / British Pakistani ☐		Chinese ☐	Other Asian Background ☐		
Other Black Background ☐	Bangladeshi / British Bangladeshi ☐		Other ☐	Ethnic Category Refused ☐		
What is your main spoken language? **Do you speak English?** Yes ☐ No ☐			**Do you need an Interpreter?** Yes ☐ No ☐			
Do you need help with mobility/hearing/speaking? (tick all that apply)						
Wheelchair ☐	Walking aid ☐		Hearing aid ☐	British sign language (BSL) ☐	Makaton sign language ☐	
Lip reading: ☐	Large print: ☐		Braille ☐	Other. ***Please state***: ☐		
Are you currently?	Homeless ☐		A Refugee ☐	An Asylum Seeker ☐		
Are you housebound?	Yes ☐ No ☐		Comments:			

Please state all countries you have lived in or visited for periods of greater than 6 months:	
Country:	**Dates/Year (If known):**

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Lifestyle	
Are you currently a smoker? ☐ Yes ☐ No **Have you ever been a smoker?** ☐ Yes ☐ No	If you smoke, how many Cigarettes / Cigars / Tobacco do you smoke in a day?
If you are a smoker and want to STOP please tick here: ☐	

Alcohol:	**Scoring System**					**Your Score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing 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 drink on a typical day when you are drinking?	**1-2**	**3-4**	**5-6**	**7-9**	**10+**	
How often have you had 6 or more units if female, or 8+ if male, on a single occasion in the last year?	Never	Less Than Monthly	Monthly	Weekly	Daily Or Almost Daily	
Alcohol Units: 1 Pint Of Premium Beer = 2.5 Units. 1 Pint Beer/Cider = 2 Units. Single Measure Of Spirit = 1 Unit. Small (125ml) Glass Of Wine = 1 Unit					**Total Score**	

Diet and Exercise	
How much exercise do you do?	**What type of diet do you have?**
☐ Sedentary (No exercise)	☐ Healthy
☐ Gentle (climbs stairs, walking , gardening)	☐ Unhealthy
☐ Moderate (Cycling, swimming regularly)	☐ Vegan
☐ Vigorous (Attends gym regularly)	☐ Vegetarian
	☐ Moderate

Please enter your height in		**Please enter your weight in**	
Feet / inches:	**cm:**	**Kilos/grams:**	**Stones / lbs:**

Women Only	What is the date of your last ***Smear test***?	Date:	Result:
Was this at your GP Surgery?	☐ Yes ☐ No	Date of last ***Mammogram*** (if applicable):	
Number of ***pregnancies*** (include miscarriages & terminations) (If applicable)			
Do you wish to see a doctor in this Practice for contraceptive services (including the pill, coil or cap)?			☐ Yes ☐ No

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Your Medical Background

Are there any serious diseases that affect your parents, brothers or sisters?
Tick all that apply *and* state family member:

☐ **Diabetes** Who:	☐ **Asthma** Who:	☐ **Thyroid disorder** Who:	☐ **Stroke** Who:	☐ **COPD** Who:
☐ **Heart Attack under age of 60** Who:	☐ **Cancer (Specify type)** Who:	☐ **High Blood pressure** Who:	**Any other important family illness. *Please state***:	Who:

Please state any allergies and sensitivities you have to medicines, food & dressings:			
Please state any mental disabilities you have:			
Are you able to administer your own medicines?	☐Yes ☐ No	***If no*** please give details, e.g. swallowing or opening containers:	
What long term medical conditions have you had?			Date of Diagnosis:
What operations or serious injuries have you had?			Date of operations or injuries:
Please list any tablets, medicines or other treatments you are currently taking / undertaking:			
We can now send your prescriptions electronically to the pharmacy of your choice. If you would like us to do this, please give the name and location of the pharmacy here:			

Chlamydia Screening:

Chlamydia is a sexually transmitted infection which often shows no symptoms but can have long term consequences. If you are aged between 15 – 24 years would you like to be screened for Chlamydia? YES / NO

For You Information

- You will have a Summary Care Record (emergency care summary) unless you let us know you wish to opt out.
- We will send text reminders to your mobile phone unless you share a mobile number or ask us not to.
- We will not give out test results or other information to someone on your behalf without your explicit written consent.
- The practice contributes anonymised data to national health research programmes. Please let us know if you wish to opt out of this programme.
- Unless you object, your health information will be used to plan and improve services for all patients nationally via the care. Data extraction service commissioned by NHS England. This information is linked to your postcode and NHS number but not your name.

Please speak to the Practice Manager if you would like more details of any of the above

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Sharing Your Medical Record

Medical Record Sharing allows your complete GP medical record to be made available to authorised healthcare professionals involved in your care. You will always be asked your permission before anybody looks at your shared medical record.
If you don't want to share your GP record 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. You will always be asked your permission before anybody looks at your Summary Care Record.
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.
I wish to OPT OUT from my Personal Confidential Data being shared outside my *GP practice*: ☐
I wish to OPT OUT from my Personal Confidential Data being shared with *third parties*: ☐

Patient Participation Group (PPG)

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 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. It will also mean we can 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 tick yes in the box below and we will contact you with further details.

Yes I am interested in becoming involved in the PPG ☐	***No*** I am not interested in becoming involved in the PPG ☐

Online Services

You can now do the following online or via the patient access app:

- Book and cancel appointments, order repeat prescriptions, view a summary of your medical record.

  IT WILL BE YOUR RESPONSIBILITY TO KEEP YOUR LOGIN DETAILS AND PASSWORD SAFE AND SECURE. IF YOU KNOW OR SUSPECT THAT YOUR RECORD HAS BEEN ACCESSED BY SOMEONE THAT YOU HAVE NOT AGREED SHOULD SEE IT, THEN YOU SHOULD CHANGE YOUR PASSWORD IMMEDIATELY.

Yes I'd like to register for online services ☐	***No*** I don't want to register for online services ☐

Other Information

Do you have a "***Living Will***"? (A statement explaining what medical treatment you would not want in the future)?	☐Yes ☐No	*If* ***"Yes",*** can you please bring a written copy of it to your first appointment?
Have you nominated someone to speak on your behalf (***e.g. a person who has Power of Attorney***)? ☐Yes ☐No	*If* ***"Yes", please state*** their Name: Address: Phone number:	

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Registration Check List:
Please Circle where appropriate when you have checked all the forms in the pack. Always ask if patient has a NHS number or NHS card or has previously been registered in the UK. For babies please ask for copies of immunisation card/Red book and if possible a copy of the birth certificate.
Proof of Name (ID).You must provide one of the following: • Current passport(with valid Visa non-EU passports) • Residence permits issued by the Home office to EU Nationals on sight of own country • Current UK photo card driving license(full UK only) • Birth Certificate • Adoption Certificates • Marriage/Civil Partnership Certificates • Police photographic ID card
Proof of Address. You must provide one of the following: • Recent (within the past three months) original utility bill e.g. 'Electricity/Gas/Water/Telephone. • Local authority council tax bill • Bank or building society statement(Within the past three months • parents documentation from "Proof of address "list (for 16-17 year olds only) This must be provided with a birth certificate or adoption certificate bearing the parents name which can be used as proof of name • Current book or card or original notification letter from the Department for Work & Pensions • Court order within the past 12 months
For Official Use Only Administrator dealing with forms:_____ Seen ID Passport:_____ Seen Proof Of Address:_____ Seen Immunisation Records_____ Fully Completed Registration/Forms_____ Patient Name:_____ D.O.B_____

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What we will do for you
• We are committed to providing the best possible service • Patients will be greeted courteously • We make every effort to see you promptly • We will treat all information confidentially • We will always offer the treatment and advice we believe is best • If you are too ill to attend the surgery a telephone consultation will be arranged and a home visit will be organised if appropriate • We will try to deal with any problems or complaints promptly • You have the right to see your medical records • The practice will inform patients of services available by means of leaflets, notice boards, posters and the website • The practice adheres to an equal opportunities policy

What you can do for us
• Please try to treat yourself for minor illnesses, such as coughs, colds, sore throats etc. • Attend the chemist if you have a minor illness and speak with the pharmacist • If your child has a minor illness take them to the chemist • Please treat staff with courtesy and respect • Please arrive promptly for your appointment • If you cannot keep your appointment notify us as soon as possible so others can have your appointment • If you arrive more than 11 minutes late we cannot guarantee you will be seen • Most delays are due to emergencies, so please be patient • Ask if you are not sure about your treatment • Many illnesses can be prevented through healthy living, please ask for health advice and leaflets

Zero tolerance
The practice supports a zero tolerance policy, and anyone who is verbally or physically abusive to any member of staff, shall be removed from the practice list.

Signature	
Patient signature:	Signature on behalf of patient:

Thank you for completing this form. ***For more information about the services we offer, please refer to our practice leaflet or see our website***