Great Oakley Medical Centre
New Patient Registration Form

Today's Date:

Please complete this confidential questionnaire (one for each member of the family to be registered with Great Oakley Medical Centre).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Proof of address seen……

Proof of date of birth seen……

<table>
<tr><td colspan="5">Full Name:</td><td>NHS Number (if known):</td></tr>
<tr><td colspan="5">Mr / Mrs / Miss / Ms / Mx / Other (please state):</td><td>Telephone Number:</td></tr>
<tr><td colspan="5" rowspan="3">Address and Postcode</td><td>Work Number:</td></tr>
<tr><td>Mobile Number:

We may wish to text you from time to time, do we have your permission: YES/NO</td></tr>
<tr><td>E-mail Address:</td></tr>
<tr><td>Housing (Select one)</td><td>House</td><td>Maisonette</td><td>Flat</td><td>Mobile Home</td><td rowspan="2">Next of Kin:

Next of Kin Contact Number:</td></tr>
<tr><td colspan="5">Date of Birth:</td></tr>
<tr><td>Marital Status:</td><td></td><td>Previous/ Mother's surname if different:</td><td colspan="2"></td><td>Town & Country of Birth:

Occupation:</td></tr>
<tr><td colspan="5">Gender:
Which of the following best describes how you think of yourself?
☐ Male (including trans men)
☐ Female (including trans women)
☐ Non-Binary
☐ In another way (please state)

Is your gender identity the same as you were assigned at birth?
☐ Yes ☐ No</td><td>Names & Ages of Children:</td></tr>
<tr><td colspan="5">Sexual Orientation:
Which of the following best describes how you think of yourself?
☐ Heterosexual/Straight
☐ Lesbian/Gay
☐ Bisexual
☐ In another way (please state)</td><td>Other residents of your home</td></tr>
</table>

Previous Address				**Previous Postcode:**		
				Previous Doctor Telephone No.		
Previous Doctor Name & Address:				**Previous data released?**	**Yes**	**No**
				If applicable, date you first came to live in Britain:		
Have you ever served in the UK Armed Forces YES / NO		**If Known, Your Service or Personnel Number**		**Your Enlistment Date** **Your Discharge Date:** **Please provide copies of Armed Forces medical records**		
Your height:	**Feet / inches**	**cm**	**Your weight:**	**Stones / lbs.**	**kg**	

Your Religion:	**C of E**	**Catholic**	**Other Christian (state)**	**Buddhist**	**Hindu**	**Muslim**
	Sikh	**Jewish**	**Jehovah's Witness**	**No religion**	**Other religion (state)**	

Your Ethnic Origin: (select one)	**White (UK) 9i0**	**White (Irish) 9i1%**	**White (Other) 9i2%**
Caribbean 9i3	**African 9i4**	**Asian 9i5**	**Other Mixed Background 9i6%**
Indian / Brit Indian 9i7	**Pakistani / Brit Pakistani 9i8**	**Bangladeshi / Brit Bangladeshi 9i9**	**Other Asian Background 9iA%**
Other Black Background	**Chinese 9iE**	**Other 9iF%**	**Ethnic Category not stated 9iG**

Your main or 1st language Spoken / Understood: (select one)		**English**	**Hindi**	**Gujurati**	**Urdu**	**Bengali /Sytheti**	**Punjabi**
Polish	**Ukrainian**	**French**	**German**	**Spanish**	**Other: (Please Specify)**		

Smoking, Alcohol Consumption and Exercise:					
Are you currently a smoker?	**Yes**	**No**	**Have you ever been a smoker?**	**Yes**	**No**
If so, how many cigarettes / cigars / tobacco do you smoke in a week?			**How much alcohol do you drink in a week (Units)?** *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)*		
If you are a smoker and want to stop, please ask for information about local smoking cessation services.					
How often do you exercise?	**No. times per week**		**Type(s) of exercise:**		

Your Medical Background:	
What illnesses have you had & when?	

What operations have you had and when?	
Do you have any medical problems at present?	
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)	Or attach a copy of your repeat prescription list

Are you able to administer your own medicines?	**Yes**	**No – please detail specific issues (e.g. swallowing, opening containers)**

Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)	**Diabetes**	**Heart Attack**	**Heart attack under age of 60**	**Bowel Cancer**
	Breast Cancer		**High Blood Pressure**	**Asthma** / **Stroke**
	Thyroid Disorder		**Any other important Family Illness?**	

What immunisations have you had? (please tick all that apply)	**Diphtheria**	**Measles**	**German Measles**	**Tetanus**	**Polio**	**MMR**
	Whooping Cough		**Pre-school booster**	**Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses**		

Accessible Information and Specific Needs:

Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:

Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):	
Are you an 'Assistance Dog' User?	
Please state any Physical disabilities you have:	
Please state any Mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises	
Please state any Religious or Cultural needs:	
Do you require the help of a Translator / Interpreter?	

Please state any specific nutritional requirements you have:		
Please state any allergies and sensitivities you have:		
Please state any phobias you have:		
If you are a Carer, please state the name / address / phone number of the person you care for:	**Person Cared For Contact Details:**	
If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer Contact Details:** **Signed:** **Date:**	
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 New Patient Consultation***
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:**

Patients with Cervixes:

When was your last smear done?	**Date**	**Was this at your GP's Surgery?**	**Yes**	**NO**
What was the result of the smear?				
Date of last mammogram (if applicable):	**Date**	**Method of contraception (if used):**		
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?			**Yes**	**NO**

Summary Care Records.

The NHS is changing the way your health information is stored and managed.
The NHS Summary Care record is an electronic record of important information about your health.
It will be available to health care staff providing your NHS Care. An information pack has been provided.

Are you happy to have a Summary Care Record?	**Yes**	**No**	**More Time Required to decide:**

Patient Participation Group

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, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.

Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box)	**Yes**

Patient Signature:		**Signature on behalf of Patient:**	
Please indicate in the box the nominated pharmacy of your choice if you would like your repeat prescription to be collected on your behalf:			
Would you like to opt out of our online repeat prescription request service:		**Yes**	**No**
Please note that the online repeat prescription request service will not be available until 2 weeks after the acceptance of your registration at the surgery. You will need to collect your password for the service from the receptionist two weeks after registering.			

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or see our website: www.greatoakleymedicalcentre.co.uk