AELFGAR SURGERY

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NEW PATIENT QUESTIONNAIRE

PERSONAL DETAILS

SURNAME:_____**FORENAMES**: _____

TITLE: MR / MRS / MISS / MS _____ **DATE OF BIRTH**: _____/_____/_____

ADDRESS:_____

_____ **POSTCODE:** _____

TEL. No. (Home) _____ (Work) _____

MOBILE No. _____

ARE YOU (Please circle) Single Married Cohabiting Separated Divorced Widowed

Do you look after a relative or friend, young or old, who is unable to care for themselves due to a physical or mental impairment or by age? Yes/ No

If so, we would like to support you and ask that you please complete the following:

Name of the person you are Caring for: ……..

their address ……

their telephone No …….

In order that we may take into account a patient's culture, religion and background when providing appropriate individual care, your assistance in completing this section is greatly appreciated as it helps us to improve our policies and practices

White British	☐	Pakistani	☐
White Irish	☐	Bangladeshi	☐
White Other	☐	Other Asian background	☐
White & Black Caribbean	☐	Black Caribbean	☐
White & Black African	☐	Black African	☐
White & Asian	☐	Other Black background	☐
Other Mixed background	☐	Chinese	☐
Indian	☐	Any Other	☐

Additional Information

Height: Weight:

As a practice we offer new patient appointments, would you like to book one: Yes/ No
Are you taking any regular medication? Yes/No

If you are on any repeat medication, please bring details of this with you on your first appointment with the GP or nurse.

Would you like access to internet appointment booking / ordering prescriptions? Yes / No
If yes, please complete the attached application form.

Summary Care Record (Please refer to additional information sheets)

☐ **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you.

☐ **No I do not want a Summary Care Record –** enclosed is an opt out form. Please complete the form and hand it to a member of the GP practice staff.

LIFESTYLE QUESTIONS

SMOKING

Do you smoke? YES / NO At what age did you start? _____

Have you ever smoked? YES / NO When did you stop? ____/____/____

What do you smoke? Please circle. Cigarettes/ Cigars / Pipe/Electronic Cigarettes

How many?

____ 1 per day ____ 1 – 9 per day ____ 10 – 19 per day ____ 20 – 39 per day ____ 40 plus per day **Would you like help to give up**? Yes/ No

ALCOHOL

Please tick the most appropriate ___ Teetotal

___ 1 unit per day ___ 1 – 2 units per day ___ 3 – 6 units per day

___ 7 – 9 units per day ___ Over 9 units per day

(Where 1 unit is equivalent to ½ pint beer, 1 small glass of wine, 1 measure of spirit).

EXERCISE

Please tick the most appropriate ___ Exercise physically impossible

___ Aerobic exercise 0 times/week ___ Aerobic exercise 1 times/week

___ Aerobic exercise 2 times/week ___ Aerobic exercise 3+ times/week

Assistance During Appointments

In order for us to provide you with any assistance you may require during consultations, please let us know if you would benefit from any of the following:-

First language **NOT** English – require a translator ☐

Deafness – require a sign language translator ☐

Disability – require a carer ☐

IDENTIFICATION DOCUMENTS REQUIRED WHEN REGISTERINGAS A NEW PATIENT

When returning the completed registration form, please bring your proof of identification. We are unable to register you without this.

PROOF OF NAME
(One of the following)

Birth Certificate
Marriage Certificate
Driving Licence (valid)*
Passport (Valid)*

PROOF OF ADDRESS;MUST BE DATED WITHIN THE LAST 3 MONTHS
(One of the following)

Utility Bill
Council Rent Book
Bank Statement
Credit Card Statement
Letter from Benefits Agency

***Please note if applying for Online Access to your medical records, photo ID must be produced.**

Information for our patients.

We're improving how we communicate with patients. Please tell us if you need information in a different format or need communication support.

Summary Care Records

NHS

Your emergency care summary

CONFIDENTIAL

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice (completed forms must be returned to your GP practice. Forms sent anywhere other than your GP practice will not be actioned).

A. Please complete in BLOCK CAPITALS

Title ..... Surname / Family name .....

Forename(s) .....

Address .....

Postcode ..... Phone No ..... Date of birth .....

NHS number (if known) ..... Signature .....

B. If you are filling out this form on behalf of another person or child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name ..... Your signature .....

Relationship to patient ..... Date .....

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please:

- phone the Summary Care Record Information Line on 0300 123 3020;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

FOR NHS USE ONLY

Actioned by practice yes/no Date .....

Ref: 4705

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 ☐
Authorised by		Date
Date account created		
Date passphrase sent		
Level of record access enabled All ☐ Prospective ☐ Retrospective ☐ Detailed coded record ☐ Limited parts ☐		Notes / explanation

FOR PRACTICE USE ONLY

	Checked By (Initials)
Registration Form completed and signed	
New Patient Questionnaire completed	
SCR option selected (Opt-Out Form completed if dissent given)	
ID Verified and photocopied	
New Patient Health Check appt made	
Check if requesting online access and if so sign to say you have seen ID	