**BEACONSFIELD ROAD SURGERY**

New Patient Registration Form

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

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

Please bring a Passport/Driving Licence to confirm your date of birth and address. Please complete a separate form for each family member to be registered.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Full Name:** | | | | | | | | | | **Telephone Number:** | | |
| **Mr / Mrs / Miss / Ms / Other……..** | | | | | | | | | | **Work Number** | | |
| **Address and Postcode** | | | | | | | | | | **Mobile Number:** | | |
| **E-mail Address:** | | |
| ***Next of Kin details – name in full:*** | | |
| ***Relationship to you:*** | | |
| **Date of Birth:** | | | **Previous / Mother’s surname if different:** | | | | | | | ***Next of Kin Emergency Contact Number:*** | | |
| **Town & Country of Birth:** | | | **Marital status:** | | | | | | |  | | |
| **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?** | |  | | | | | | | | | | |
| **Pharmacy nomination for prescriptions** | | Please ensure that you nominate a local pharmacy for your prescriptions to be sent to; these are all handled electronically:  …………………………………………………………………………………………… | | | | | | | | | | |
| **Please list any tablets, medicines or other treatments you are currently taking:**  **(incl. dose + frequency)** | |  | | | | | | | | | | |
| **Are you able to administer your own medicines?** | | **Yes** | | | **No – please detail specific issues (e.g. swallowing, opening containers)** | | | | | | | |
|  | | | | | | | | | | | | |
| **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*** | | | | | |
|  | | | | | | | | | | | | |

***Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing.***

***The Consultation will also establish relevant past medical and family history, including:***

* ***Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health***
* ***Social factors - employment, housing, family circumstances***
* ***Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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 in joining, 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 keep you 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  (If interested, tick the “Yes” Box)** | | | | **Yes** |
|  | | | | |
| **Patient**  **Signature:** |  | **Signature on**  **behalf of Patient:** |  | |

**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.beaconsfieldroadsurgery.co.uk\*\*\****

|  |  |
| --- | --- |
| **If you have served or are currently serving in the Armed forces, please select the relevant section.** | **Serving Armed Forces**  **Armed forces reservist Military Veteran**  **Non-commissioned officer Trainee- Armed forces**  **Families**  **Dependant of former serving member of British Armed Forces**  **Dependant of current serving member of British Armed forces**  **Member of military family**  **Veterans**  **Military veteran**  **Served in Armed forces**  **Armed forces reservist** |

DUE TO RENEWED GOVERNMENT GUIDELINES WHEN REGISTERING NEW PATIENTS GP’S ARE REQUIRED TO ASK IF YOU OR SOMEONE CONNECTED TO YOU IS CLASSED AS A VULNERABLE PERSON, THEREFORE WE WOULD BE MOST GRATEFUL IF YOU COULD ANSWER THE FOLLOWING 2 QUESTIONS –

1) DO YOU CURRENTLY LIVE WITH SOMEBODY WHO IS CLASSED AS A VULNERABLE ADULT/CHILD? (Please circle)

YES NO

If yes, who is this person to you? ……………………………………………………………………….

2) DO YOU HAVE ANY FAMILY MEMBERS CLASSED AS VULNERABLE?

YES NO

If yes, please specify ………………………………………………………………………………………….

Signed ……………………………………………………………………………………………………………………………

All information provided in your answers is strictly confidential and will not be passed onto any other party.

**SUMMARY CARE RECORD – PLEASE READ CAREFULLY**

The Summary Care Record is a copy of key information from your GP record. It provides authorised care professionals working elsewhere in the NHS with faster, secure access to essential information about you when you need care. You can choose whether you want a Summary Care Record and how much information it contains.

|  |  |
| --- | --- |
|  | Please tick ONE option below |
| **I would like a Summary Care Record with Additional Information.**  This record includes any allergies, adverse reactions or medications you are taking, as well as significant medical history (past and present), reasons for medications, and care plan information (if any). |  |
| **I would like a Summary Care Record with Core Information only**  This record will ONLY include the medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had in the past. |  |
| **I do not want a Summary Care Record**  No Summary Care Record will be created for you, but you are free to change your decision at any time by informing your GP practice. |  |

**Signed ……………………………………………………………………………………….**

**Date …………………………………………………………………………………………**

**PATIENTS AGREEMENT**

**On joining Beaconsfield Road Surgery please be prepared to see a Nurse instead of a Doctor for minor illnesses or when appropriate. Our Nurses are skilled and an essential part of our patient care team.**

**We also ask patients to agree not to be abusive to staff. We have a zero tolerance policy and will remove any such patients from our list.**

**It is the patient’s responsibility to notify us of any change of details, ie, name, address and telephone number so we can update your records.**

**Patients who regularly fail to attend appointments without cancelling may be removed from our Practice list.**

**Print name ………………………………………………………………………………………………………………**

**Signature ………………………………………………………………………………………………………………..**

**Date ………………………………………………………………………………………………………………………**

**BEACONSFIELD ROAD SURGERY ONLINE SERVICES**

**Consent Form**

|  |  |
| --- | --- |
| I agree to use the system in a responsible manner in accordance with the terms and conditions on the online website.  Access may be withdrawn if services are used inappropriately. | YES / NO |
| I agree that it is my responsibility to keep secure the username and passwords I will be given. If I think these have been shared inappropriately I will reset them using the instructions on the online website. | YES / NO |
| I agree that online services are provided at the discretion of the Practice, and may be withdrawn by the Practice at any time. | YES / NO |
| I agree to keep the Practice informed about any changes to contact details. In particular, it is important that the Practice is given new mobile numbers when there is a change, as this can happen even when not moving home. | YES / NO |

**I would like to register to use the Practice’s online services – I am over 18 years old:**

**Patient Details**

|  |  |
| --- | --- |
| Surname |  |
| First Name |  |
| Date of Birth |  |
| Address |  |
| Postcode |  |
| Telephone Number |  |
| Mobile Number |  |
| Email  Please note this email address will be used to send or reset your confidential login details |  |

To be signed at reception by patient ………………………………………………………………..

Print Name ………………………………….. Date ……………………………………………………….

**For Office use only**: State ID seen …………………………………………..

Online account letter created and handed to patient Date: ……………………………

**Terms & Conditions for using Online Services**

**About Patient Access**

Patient Access is only available to patients who are registered with our surgery.

Using Patient Access, you can now view, book and cancel appointments at Beaconsfield Road Surgery and request repeat medication prescriptions from home, work or on the move - wherever you can connect to the internet. What's more, because Patient Access is a 24 hour online service - you can do this in your own time, day or night.

**Confidentiality and Security**

Information sent via Patient Access is encrypted.  This means that messages sent cannot be intercepted or read by others, and only the Patient and the Practice are able to see any personal information.

The computer system is connected to Patient Access through the NHS network, which is more secure than a normal internet connection. The Surgery will only enable the internet access facilities if requested to do so by the Patient.

**Terms and Conditions**

Whilst the Surgery makes all reasonable efforts to provide the Service, it is not liable for any failure to provide the Service, in part or full, for any cause that is beyond its' reasonable control.

This includes, in particular, any suspension of the Service resulting from maintenance and upgrades to the systems or those of any party used to provide the Service.

You must keep your Personal Details secret and take all reasonable precautions to prevent the fraudulent use of your Personal Details.  If fraudulent use is suspected, contact the Surgery as soon as possible.

1. This facility is currently available for ROUTINE doctors' appointments only, to discuss a single issue.
2. The system is set to allow two appointments to be booked online at any one time.
3. All booked appointments are cancellable on-line; if an appointment booked on-line, is not cancelled without good reason, and results in a 'did not attend', the Surgery reserves the right to revoke its use and remove the patients from our list.
4. If your selected GP becomes unavailable at short notice we may move your appointment to another GP without notification.
5. If the appointment cannot be found on our system we will only honour the appointment if you have printed the confirmation of booking
6. Requests for repeat medication prescriptions will take 2 working days to process.

If you would like access to your basic medical record which includes medications, allergies and immunisations then please tick the box.

Beaconsfield Road Surgery reserves the right to change the Service from time to time and shall give appropriate notice of any material changes.  They may, where considered appropriate for patient protection, suspend, withdraw or restrict the use of the Service or any part of the Service.  Patients will be notified as soon as practicable if any such action is taken.  The surgery reserves the right to vary these Terms and Conditions and appropriate notice will be given of any material changes.

Patient Name:………………………………………………………………………….

Signed:………………………………….. Date:…………………………………