**ADULT REGISTRATION – OVER 16**

***Please ensure that the following is brought in for your registration***

**GMS1 – Check all information is completed**

* + Name
  + Previous Surname (i.e. Maiden Name. If name change via Deed Poll or Divorce – original documents required)
  + DOB and NHS Number
  + Town and Country of Birth
  + Address
  + Telephone Number (Mobile and Home)
  + Previous Address and Previous GP
  + If you are from abroad – date 1st came to UK
  + **Signature & Dated**

**NEW PATIENT QUESTIONAIRE -** complete all required information including:

* + Pharmacy
  + Sharing your health records

**ONLINE ACCESS (**Recommended)

If you would like Online access to request repeat medication, book appointments or access your medical records, please read and complete the enclosed Online Access form and **provide photo ID** (e.g. Passport or Driving licence).

**REPEAT MEDICATION: If you are on repeat medication please ensure you have enough for at least 30 days from your current surgery. You will also need to book an appointment with a GP to review your medication before you submit a new repeat prescription request.**

Note: You will be registered between **seven and ten** days after dropping off your registration documentation.

**Tile House Surgery - New Patient Registration Form: ADULT**

Please complete all pages in full using block capitals

|  |
| --- |
| **1. Background Details** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Contact Details** | | | | | | | |
| Name |  | | | Date of Birth | |  | |
| Gender | Which of the following best describes how you think of yourself?  Man (including trans man)  Woman (Including trans woman)  Non-Binary  Prefer not to say | | | Gender Identity | | Is your gender identity the same as the gender you were given at birth?    Yes  No | |
| Sexual Orientation | Straight or Heterosexual  Lesbian or Gay | Bisexual  Prefer not to say | | | | Other: ……………… | |
| Address |  | | | | | | |
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|
| Mobile Number |  | | I consent to be contacted by SMS\* | | | | Yes / No |
| Home telephone |  | | I consent for the surgery to leave messages on the home answerphone\* | | | | Yes / No |
| Email address |  | | | | I consent to be contacted by email address\* | | Yes / No |
| Emergency contact details/ Next of Kin | Name: | | | | | | |
| DOB: | | Tel: | | | | |
| Relationship: | | | | | | |

***\* It is your responsibility to keep us updated with any changes to your contact details.***

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Other Details** | | | | | | | | | | | |
| Ethnicity | White (UK)  White (Irish)  White (Other):  …………………… | | | | | Black Caribbean  Black African  Black (Other):  ……………………. | | Bangladeshi  Indian  Pakistani | Chinese  Other: ………………..…….  Prefer not to say | | |
| Have you ever been a member of the **British** Armed Forces? | Yes | | | If Yes, please indicate which Armed Force  Army  Navy  Marines  RAF  Other ………………………….  Date From and To: ………………………………………………………………. | | | | | | | |
| **Communication Needs** | | | | | | | | | | | |
| Language | | What is your main spoken language? ……………………………………………………..…….  Do you need an interpreter?  Yes  No | | | | | | | | | |
| **Carer Details** | | | | | | | | | | | |
| Are **you** a carer? | | | Yes – Informal / Unpaid Carer | | | | Yes – Occupational / Paid Carer | | | |  |
| Do you **have** a carer? | | | Yes | | Name\*: | | Tel: | | | Relationship: | |

*\* Only add carer’s details if they give their consent to have these details stored on your medical record*

|  |  |
| --- | --- |
| Are you registered disabled? | Yes  No |

|  |
| --- |
| **2. Medical History** |

|  |
| --- |
| **Current Prescribed Medication** |
| Are you on any repeat medication?  Yes  No |
| ***If you are on repeat medication, please ensure you have at least 30 days of medication from your current surgery and ensure you make an appointment with a GP before you put in a new prescription request with us.*** |

|  |  |
| --- | --- |
| **Prescriptions** | |
| Name of pharmacy you would like your prescriptions to be sent to: | Pharmacy: |

|  |  |
| --- | --- |
| **Allergies** | |
| Please record any allergies or sensitivities below: | Symptoms: |

|  |  |
| --- | --- |
| **Pregnancy** | |
| Are you currently pregnant or think you may be? | Yes  No Expected due date: |

| **3. Lifestyle** |
| --- |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Smoking** | | | | |
| Do you smoke? | Never smoked | Ex-smoker | | Yes |
| How many cigarettes did/do you smoke a day? | Less than one | 1-9 10-19 | 20-39  40+ | |
| Do you use an e-Cigarette? | No | Ex-User | Yes | |
| Would you like help to quit smoking? | For further information, please see: [www.nhs.uk/smokefree](http://www.nhs.uk/smokefree)  or Call: Essex Wellbeing Service: 0300 303 9988 | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Alcohol** | | | | | | | |
| Please answer the following questions which are validated as screening tools for alcohol use: | | | | | | |
| **AUDIT–C QUESTIONS** | **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 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  | |
| A score of **less than 5** indicates *lower risk drinking***.** | | | | | TOTAL: |  | |

**Scores of 5 or more requires the following 7 questions to be completed:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **AUDIT QUESTIONS**  (after completing 3 AUDIT-C questions above) | **Scoring System** | | | | | **Your Score** |
| **0** | **1** | **2** | **3** | **4** |
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you failed to do what was normally expected from you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |
| Have you or somebody else been injured as a result of your drinking? | No |  | Yes, but not in last year |  | Yes, during last year |  |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No |  | Yes, but not in last year |  | Yes, during last year |  |
| **If you would like help with alcohol reduction, please contact Essex Wellbeing Service: 0300 303 9988 / www.essexwellbeingservice.co.uk** | | | | | TOTAL: |  |



|  |
| --- |
| **4. Sharing your Health Record** |

|  |
| --- |
| **Your Health Record** |
| Do you consent to your GP Practice sharing your health record with other organisations who care for you?  Yes *(recommended option)*  No *(not recommended, please discuss this with your GP before ticking this option)*  Do you consent to your GP Practice viewing your health record from other organisations that care for you?  Yes *(recommended option)*  No |

**Sharing Your Health Record**

Your health record contains all the clinical information about the care you receive. When you need medical assistance, it is essential that clinicians can securely access your health record. This allows them to have the necessary information about your medical background to help them identify the best way to help you. This information may include your medical history, medications and allergies.

Health records about you can be held in various places, including your GP practice and any hospital where you have had treatment. Sharing your health record will ensure you receive the best possible care and treatment wherever you are and whenever you need it. Choosing not to share your health record could have an impact on the future care and treatment you receive. Below are some examples of how sharing your health record can benefit you:

* Sharing your contact details This will ensure you receive any medical appointments without delay.
* Sharing your medical history This will ensure emergency services accurately assess you if needed.
* Sharing your medication list This will ensure that you receive the most appropriate medication.
* Sharing your allergies This will prevent you being given something to which you are allergic.
* Sharing your test results This will prevent further unnecessary tests being required.

**New Patient checklist**

**Please tick all the boxes below to confirm you have completed and understood the requirements for new patients so that your registration can be completed successfully.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Completed & Signed GMS1 Form | | | |
|  | Completed & Signed New Patient Questionnaire | | | |
|  | If you are on repeat medication, please ensure you have at least 30 days of medication from your current surgery and ensure you make an appointment with a GP before you put in a new prescription request with us (please tick to confirm you understand this even if you do not have any repeat medication). | | | |
|  |  | | | |
| **Signatures** | | | |
| I confirm that the information I have provided is true to the best of my knowledge. | | | |
| Signature | |  | Signed on behalf of patient |
| Print Name | |  | |
| Date | |  | |



**Tile House Surgery**

**Patient Online Registration Form**

**Access to GP Online Services**

Please read the information overleaf before completing this form and **provide photo ID**

**(e.g. Passport or Driving licence).**

|  |  |  |  |
| --- | --- | --- | --- |
| **Surname** |  | | |
| **First name** |  | | |
| **Date of birth** |  | | |
| **Address** |  | | |
| **Postcode** |  | | |
| **Email address** |  | | |
| **Telephone number** |  | **Mobile number** |  |

## This will give you access to the following online services**:**

* Booking appointments
* Requesting repeat prescriptions
* Accessing my medical record and viewing test results

I wish to access my medical record online and understand and agree with each statement (please tick)

|  |  |
| --- | --- |
| 1. I have read and understood the information on the reverse of this form | 🞏 |
| 1. I will be responsible for the security of the information that I see or download | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | 🞏 |
| 1. If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible | 🞏 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signature** |  | **Date** |  |

### For practice use only:

Coded: Xabui / Registered for online access.

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified through | Photo ID 🞏 | Name of verifier | Date |
| Name of person who authorised (if applicable) |  | | Date |

**Important Information – Please read before returning this form**

If you wish to, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medications you take regularly and look at your medical record online. You can also still use the telephone or call in to the surgery for any of these services as well. It’s your choice.

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.

If you can’t do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.

During the working day it is sometimes necessary for practice staff to input into your record, for example, to attach a document that has been received, or update your information. Therefore, you will notice admin/reception staff names alongside some of your medical information – this is quite normal.

The definition of a coded record is all the information that is in the record in coded form, such as diagnoses, signs, and symptoms (such as coughing, headache etc.) but excludes letters, documents and free text.

## Before you apply for online access to your record, there are some other things to consider.

Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.

|  |
| --- |
| **Forgotten history**  There may be something you have forgotten about in your record that you might find upsetting. |
| **Abnormal results or bad news**  If your GP has given you access to test results or letters, you may see something that you find upsetting to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them. |
| **Choosing to share your information with someone**  It’s up to you whether or not you share your information with others – perhaps family members or carers. It’s your choice, but also your responsibility to keep the information safe and secure. |
| **Coercion**  If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time. |
| **Misunderstood information**  Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation. |
| **Information about someone else**  If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible. |

For further information, please see:

[www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/gp-online-services.aspx](http://www.nhs.uk/NHSEngland/AboutNHSservices/doctors/Pages/gp-online-services.aspx)