New Patient Registration Form
(Adult: 16 and over)

ST MARY'S SURGERY
Church Close, Andover, Hants, SP10 1DP
01264 361424 www.stmaryssurgery.co.uk

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

1

Full Name: | **Date of Birth:** / /

Preferred Name/Known By:

Title : ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Mx

Gender recorded on NHS record: ☐ Male ☐ Female

As a surgery, we respect that not everyone may identify as male or female, however we are required to record a gender on our medical records at this time.

Other. *Please state* :

Marital Status:

NHS no *(if known)*:

Previous name(s) if applicable:

Mobile tel. number:

Text messaging service enables your GP Practice to get in touch with you by sending text messages to your mobile phone (e.g. text appointment reminders). You are able to text back to cancel or rebook your appointments and send responses to questions.

IF YOU CHANGE YOUR MOBILE NUMBER, PLEASE LET YOUR GP KNOW AS SOON AS POSSIBLE.

If you don't want to receive text messages from your practice tick here: ☐

Current Full Address:

Postcode:

Do you live in a residential/nursing home?:

☐ Yes ☐ No

Home tel. number:

Work tel. number:

E-mail address:

If you consent to us sending you emails to this address please tick here: ☐

Next of Kin:

Relationship to Patient:

Next of Kin contact tel. number:

Please indicate your first choice of contact method:

☐ Letter ☐ Email ☐ SMS (text) ☐ Phone

Birth Place: **Country:**

If you are from abroad, date you first came to live in the UK:

Previous UK Full Address:

Postcode:

Previous GP Practice:

Postcode:

2 **Looking After Someone**

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 :	

3

Contacting you

We will use your contact details to send reminders about appointments, reviews and other services which may be of benefit in your medical care

Do you consent to the Surgery sending letters to your home address?	☐ **Yes**	☐ **No**
Do you consent to the Surgery sending text messages to your mobile?	☐ **Yes**	☐ **No**
Do you consent to the surgery sending you messages via email?	☐ **Yes**	☐ **No**
Do you consent to the surgery leaving you messages on your phone?	☐ **Yes**	☐ **No**

4 **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**	☐ **Homemaker/Stay at home spouse/parent**	☐ **Unemployed**

☐ **Other** ***Please state***:

If returning from the Armed Forces please state which below:

☐ ☐ **Army** ☐ **Royal Navy** ☐ **Royal Air force** **Other:**

5

Service Families and Military Veterans

As a practice, we fully support the Armed Forces Covenant. We can only do this if we know our patients' connections to the Armed Forces. Please tick the below boxes that apply to you:

If you are not employed, please indicate which best describes you:

☐ **I AM** a Military Veteran		☐ **I AM** married to/in a civil partnership with a serving member of the Armed Forces.
☐ **I AM** under 18 and my parent(s) are Military Veteran(s)		
☐ **I AM** married to/in a civil partnership with a Military Veteran	☐ **I AM** currently serving in the Reserve Armed Forces	☐ **I AM** under 18 and my parent(s) are serving member(s) of the Armed Forces

6

Your Religion (Please tick)	☐ C of E	☐ Catholic	☐ Other Christian *_____	☐ Bhuddist	☐ Hindu	☐ Muslim
	☐ Sikh	☐ Jewish	☐ Jehovah's Witness	☐ No religion	☐ Other religion *_____	

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 ☐

Disabilities / Accessible Information Standards

As a practice we want to make sure that we give you information that is clear to you. For that reason we would like to know if you have any communication needs.

Do you have any special communication needs that you would like us to be aware of?

☐ Lip reading	☐ Large print	☐ Hearing aid	☐ British sign language (BSL)	☐ Makaton sign language
☐ Braille	☐ Other ***(Please state)*** *_____			

Do you have any physical needs that you would like us to be aware of when it comes to arranging appointments etc?

☐ Wheelchair/ mobility scooter	☐ Walking aid	☐ May require assistance	☐ Other ***(Please state)*** *_____

Are you registered as housebound?	☐ Yes	☐ No

Other comments:

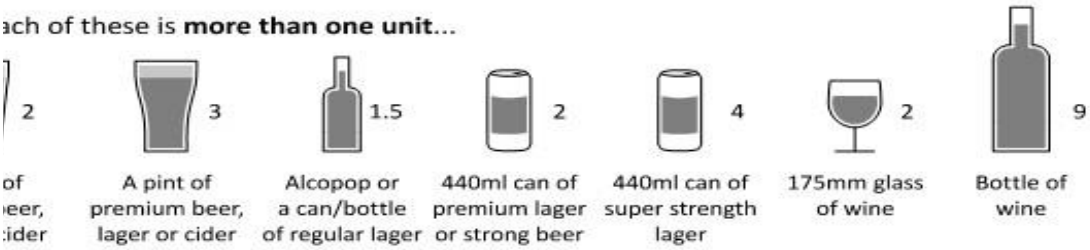
7	Lifestyle			
	Are you currently a smoker? Yes ☐ No ☐ **Have you ever been a smoker?** Yes ☐ No ☐		If you smoke, how many Cigarettes / Cigars / Tobacco do you smoke in a day?	
	Smoking is the UK's single greatest cause of preventable illness Stopping smoking is not easy but it can be done, and there is now a comprehensive, NHS Smoking Cessation Service offering support and help to smokers wanting to stop, with cessation aids available on NHS prescription. *If you would like help and advice on how to give up smoking, please contact* https://www.smokefreehampshire.co.uk/.			
	Please enter your height in		**Please enter your weight in**	
	Feet / inches:	**cm:**	**Kilos/grams:**	**Stones / lbs:**

Alcohol

Alcohol consumption is measured in units, which is explained in the diagram below.

ne unit...

ach of these is more than one unit...



Questions about your Alcohol Consumption	Scoring System 0	1	2	3	4	Your score
1. 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	
2. 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+	
3. 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	
If your total score for the above 3 questions is 4 or less, then you do not need to complete the questions below						
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	
5. 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	

6. 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	
7. 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	
8. 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	
9. Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. 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 the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence.

General Practice Physical Activity Questionnaire

1. Please tell us the type and amount of physical activity involved in your work. ***Please mark one box only***

a	I am not in employment (e.g. retired, retired for health reasons, unemployed, fulltime carer etc.)	
b	I spend most of my time at work sitting (such as in an office)	
c	I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.)	
d	My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.)	
e	My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)	

2. During the *last week*, how many hours did you spend on each of the following activities? *Please answer whether you are in employment or not*

		None	Some but less than 1 hour	1 hour but less than 3 hours	3 hours or more
a	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.				
b	Cycling, including cycling to work and during leisure time				
c	Walking, including walking to work, shopping, for pleasure etc.				
d	Housework/Childcare				
e	Gardening/DIY				

3. How would you describe your usual walking pace? Please mark one box only.

Slow pace Steady (i.e. less than 3 mph) ☐ average pace ☐

Brisk pace (i.e. over ☐ 4mph) Fast pace ☐

8 Blood and Organ Donation

From 2020, all patients will be automatically registered as organ donors, unless they have previously opted out.

For more information regarding this or to ask about opting out, please go to https://www.organdonation.nhs.uk/ or phone 0300 123 2323.

☐ Are you a registered blood donor? **Yes** **No**

9 Women Only

What is the date of your last ***Smear test***? (Also known as a ***PAP*** or ***Cervical smear***) Date: Result:

Was this at your GP Surgery? ☐ Yes ☐ No

Please specify who processed your ***Smear test*** :

☐ NHS ☐ Private ☐ Abroad

Date of last ***Mammogram*** (if applicable):

Are you currently pregnant? If you are not currently under the care of a midwife, please speak with reception. ☐ Yes EDD: ☐ No

Do you currently have a long-acting reversible contraception in place (coil/implant)? ☐ Yes No

If yes, please state type and date fitted:

10 **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:

Do you suffer from any of the following chronic conditions?

Chronic condition	**Date of diagnosis**	**Medicines you are currently taking**	**Date of Last Review (*if known*)**
Diabetes Mellitus Type I			
Diabetes Mellitus Type II			
Stroke			
Ischaemic Heart Disease			
Hypertension			
Emphysema			
Chronic Bronchitis			
Asthma			
Chronic Kidney Disease			
Depression			
Schizophrenia			
Bipolar Disorder			
Other (please state):			

Please state any allergies or sensitivities to any medicines, food or dressings:

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 medications that you are taking:

Name of medication?	What condition is it for?	How many do you take and how often?	What is the dose/strength?

Covid Vaccination Status

First Vaccination	**Date given:**	**Type:**	**Location given:**
Second Vaccination	**Date given:**	**Type:**	**Location given:**
Third Vaccination	**Date given:**	**Type:**	**Location given:**

11 Sharing Your Medical Record

Summary Care Record:

If you decide to have a SCR, it will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had it will also include basic information about your current diagnoses. Giving healthcare staff access to this information can prevent mistakes being made when caring for you in an emergency or when your GP practice is closed. Your Summary Care Record will also include your name, address, date of birth and your unique NHS Number to help identify you correctly. If you and your GP decide to include more information it can be added, but only with your express permission.

For more information: Phone 0300 123 3020 or visit www.nhscarerecords.nhs.uk

I do not wish to have a Summary care Record
(N.B. this will mean NHS Healthcare staff caring for you may not be aware of your current medications, any allergies or reactions to previous medication.) ☐

12 Electronic Prescribing Service (EPS)

The EPS allows prescribers – such as GPs and practice nurses to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. If you consent to this, please write your preferred pharmacy below:

Nominated Pharmacy:	

13 Online Services

The NHS App is a simple and secure way to access a range of NHS services on your smartphone or tablet. You can also access NHS App services from the browser on your desktop or laptop computer.

You can use the app to:

- check your symptoms
- find out what to do when you need help urgently
- book and manage appointments at your GP surgery (when available)
- order repeat prescriptions
- view elements of your GP medical record securely (including test results and vaccinations, such as Covid) - etc.

For more information and to register, go to https://www.nhs.uk/nhs-app/ or follow the guidelines on our website.

14 Other Information

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

15 NHS (Charges to Overseas Visitors) Regulations Self Declaration

I am a British resident and entitled to full NHS care ☐

I am not ordinarily resident in the UK ☐ For more information and guidance, please go to www.nhs.uk or www.gov.uk.

Please complete the next form if you are not a British resident or are unsure of your current status.

PATIENT DECLARATION for all patient who are not ordinarily resident in the UK

Patient's details

Please complete in BLOCK CAPITALS and tickick ☑ as

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice.

However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided. Please tick one of the following boxes:

a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice

b) ☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested

c) ☐ I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		**Date:**	DD MM YY
Print name:		**Relationship to patient:**	
On behalf of:			

Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS

Do you have a non-UK EHIC or PRC?	**YES:** **NO:**	If yes, please enter details from your EHIC or PRC below:
	Country Code:	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	DD MM YYYY
PRC validity period (a) From:	DD MM YYYY	(b) To: DD MM YYYY

If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.

☐ Please tick if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff**.

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

PATIENT CHECKLIST

Thank you for completing this form. Please check you have completed all sections where possible. Please ensure that you bring the following with you to the surgery to complete your registration:

1. ☐ **Completed & Signed New Patient Registration Questionnaire** (this form!)
2. ☐ **Photo Proof of ID** - e.g. Passport, Photo Driving License or Photo ID card
3. ☐ **Proof of Address** – ***Must be in your name and dated within the past 3 months***
   – *Provided in one of the following:* Bank statement, Utility Bill (Gas, Electricity, Water), Council Tax, Tenancy Agreement, etc.
4. ☐ If possible, your **Immunisation Records** – usually the Personal Child Health Record ("Red Book")
5. ☐ If relevant, your **Repeat Medication Request Slip** from your previous GP

Patient Agreement

- **I agree to attend on time for all appointments that I book with the Practice and to cancel in advance any appointment that I cannot attend. I acknowledge that should I arrive late for an appointment I may be asked to wait until the end of surgery or rebook for another time.**
- **I understand that my appointment is for 10 minutes only and, to be fair to other patients waiting, the doctor/nurse may only be able to deal with one problem during this time.**
- **I agree to request repeat prescriptions on 5 working days' notice of my need for medication. I agree to make my request either in person, by letter or through the website/NHS app. I acknowledge that requests cannot be made by telephone.**
- **I agree NOT to behave in an abusive, threatening or otherwise aggressive manner to any member of the practice staff. I am aware that the practice operates a zero tolerance policy and I acknowledge the right of the practice to remove me from their list without appeal.**
- **I confirm that I have completed this form as accurately and honestly as possible and would like to apply to be registered as a patient at this practice.**

Signature:	**Date:**
Printed name:	Name if signing on behalf of patient:

We the Practice declare that we shall not disclose any information regarding the patient without the patient's written consent.

We are registered under the Data Protection Act 2018 and have robust systems in place to protect your confidentiality. For more information, please see our website.

Office use only

Received by:	Date:
Patient ID/proof of address checked by:	Date:
Registration completed by:	Date:

Within Catchment?	☐ Yes ☐ In existing patient household		Needs Alcohol Advice Letter?	☐ Yes ☐ No
Photo ID seen:	☐ Passport	☐ Driving licence	☐ Identity card	☐ Other
Proof of Address:	☐ Utility Bill	☐ Tenancy Agreement	☐ Bank Statement	☐ Other
Nominated GP:	☐ Patient advised		☐ Patient not advised (add reminder to record)	

Covid Vaccination Status:	☐ Yes ☐ No	☐ Coded ☐ Task sent
Patient Declaration Completed:	☐ Yes ☐ No	☐ Emailed

Annex C – Consent for text messaging service

Patient consent for text message communication

Patient details			
Surname		**Forename**	
Title		**Date of birth**	
Mobile number			

I understand that I have chosen to use the text messaging communication service provided by St Mary's Surgery.

I confirm that the service has been explained to me and the kind of information that will be communicated by text message. I also understand that this service is one-way, and I am unable to respond via text. Instead, I must contact the organisation by telephone should I have a query.

I acknowledge that text messaging is not a secure system and, as a result, there is a possibility that my text may be intercepted by someone else. However, it has been explained to me that no personal identifiable information will be included in text messages and that it is my responsibility to ensure that my mobile phone contact number is up to date at all times.

Please ✓ the following statements that apply:

The mobile telephone number given is my chosen number for communication ☐
or

The mobile telephone number given is the number of my nominated person ☐

Only complete this section if applicable

Nominated person details			
Surname		**Forename**	
Title		**Relationship**	

Patient's name		**Date**	
Signature			

Patient's name		**Date**	
Signature			

For staff use only: The system has been updated to reflect the patient's agreement to text messaging communication ☐