**Reception Sign Off – Page 1 - for reception use only**

**Proof of Identity – For Reception Staff to complete**

Under NHS counter-fraud measures, we are required to ask for your proof of identity. Type- *(please tick)*

Passport Driving Licence Birth Certificate Utility Bill

Bank Statement Rent Card Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Copy Taken - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide at least one item of identification from list A and one item from List B. One of these documents **MUST** show your current address that you are using to register at Village Surgery.

List A

Passport, Driving Licence, Home Office Papers, NHS Medical Card, National Insurance Number Card, Birth Certificate.

List B

Marriage Certificate, Local Authority Rent Card, Paid Utility Bill (under 3 months old), Benefits Agency Letter/Benefit Book/Signing On Card, Current Payslip or P45.

**(Note: The following are NOT acceptable as proof of identity – library card, health club membership card, private rent book, loyalty cards, membership cards, credit and debit cards.)**

**Reception – Checklist**

|  |  |
| --- | --- |
| **Details** | **Confirmed (Please Initial)** |
| Patients full name, Address, DOB |  |
| Contact – Telephone number, email address, sms consent |  |
| Next of Kin Details – If child requires Mother / Father |  |
| If Baby – NHS number required |  |
| Previous address recorded |  |
| Previous GP recorded |  |
| Check if patient is from abroad – all data recorded |  |
| Ethnicity recorded |  |
| Check communication / Language needs |  |
| Check Medical History completed |  |
| Check – Current Medication (Repeats list – advise needs at least 1 month supply of medication) |  |
| Pharmacy Nomination |  |
| Sharing information completed |  |
| SystmOnline set up – requires email address |  |

**New Patient Registration Form** Please complete all pages in full using block capitals

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

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| --- | --- | --- | --- | --- | --- | --- |
| **Contact Details** | | | | | | |
| NHS Number |  | | | *If you have had a previous GP then you will find this on letters/prescriptions or at* [*www.nhs.uk/find-nhs-number*](https://eur01.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.nhs.uk%2Ffind-nhs-number&data=04%7C01%7Csupport%40ardens.org.uk%7Cffabf11787fb41dc43be08d99fa70d67%7C2574bae132844b5a8833850acab88d43%7C1%7C0%7C637716362095841893%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=MF3g4y6zrx4E0Qifat%2FgKNmjXrzmgNeU5ebPuaEcNAo%3D&reserved=0) | | |
| Title |  | | | Gender | |  |
| Name: |  | | | | | |
| Address |  | | | Postcode | |  |
| Date of Birth | |  |
| Home Telephone | |  |
| Previous Address |  | | | | | |
| Mobile Telephone |  | | Consent for SMS | | Yes  No | |
| Email |  | | | | | |
| Next of Kin: |  | | Relationship: | |  | |
| Tel: |  | |  | |  | |
| Mothers Name: |  | | Tel: | |  | |
| Address: |  | |  | |  | |
| Fathers Details |  | | Tel: | |  | |
| Address: |  | |  | |  | |
| Family Registered With Us | |  | | | | |
| Has the patient been registered in the NHS before?  Yes  No  If no please state date entered UK: | | | | | | |

*\* It is your responsibility to keep us updated with any changes to your telephone number, email & postal address.*

*We may contact you with appointment details, test results, health campaigns or Patient Participation Group details*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Other Details** | | | | | |
| Previous GP | Name: | | Address: |  | |
| Country of Birth |  | | | | |
| Ethnicity | White (UK)  White (Irish)  White (Other) | Black Caribbean  Black African  Black Other | | Bangladeshi  Indian  Pakistani | Chinese  Other |
| Religion | C of E  Catholic  Other Christian | Buddhist  Hindu  Muslim | | Sikh  Jewish  Jehovah’s Witness | No religion  Other: |
| Employment | Employed  Self-employed | Student  Unemployed | | House husband  House wife | Carer  Retired |
| Overseas Visitor | Yes | European Health Insurance Card Held (please bring details with you) | | | |
| Armed Forces | Military Veteran | Family member | |  |  |

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| --- | --- | --- | --- |
| **Communication Needs** | | | |
| Language | What is your main spoken language?  Do you need an interpreter?  Yes  No | | |
| Communication | Do you have any communication needs?  Yes  No (If **Yes** please specify below) | | |
| Hearing aid  Lip reading | Large print  Braille | British Sign Language  Makaton Sign Language  Guide dog |
| Learning disability | Do you have a Learning Disability?  Yes  No  (If **Yes** please request a Learning Disability Screening Tool form) | | |

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| --- | --- | --- | --- | --- | --- |
| **Carer Details** | | | | | |
| **Are you** a carer? | Yes – Informal / Unpaid Carer  Yes – Occupational / Paid Carer  No | | | | |
| 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*

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| **2. Medical History** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Medical History** | | | |
| Have you suffered or currently suffer from any of the following conditions? | | | |
| Asthma  COPD  Epilepsy | Heart Disease  Heart Failure  High Blood Pressure | Diabetes  Kidney Disease  Stroke | Depression  Underactive Thyroid  Cancer- Type: |
| Any other conditions, operations or hospital admission details:  If you are currently under the care of a Hospital or Consultant outside our area, please tell us here: | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Family History** | | | |
| Please record any significant family history of close relatives with medical problems and confirm which relative e.g. mother, father, brother, sister, grandparent | | | |
| Asthma………………….  COPD………………...…  Epilepsy………………… | Heart Disease……….…  Stroke…………….……..  Blood Pressure………… | Diabetes………..………  Kidney Disease..………  Liver Disease..….…….. | Depression………..……  Thyroid…………..….…..  Cancer………………….. |
| Other: Please highlight  FH: Atopy, FH: Asthma, FH: Hay fever, FH: Emphysema, FH: Asthma, Family history, FH: Hypertension, FH: Bowel cancer | | | |

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| **Allergies** |
| Please record any allergies or sensitivities below |

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| --- | --- |
| **Current Medication** | |
| Please check and include as much information about your current medication below  Please give us your previous repeat medication list if possible and a medication review appointment may be needed | |
| **Pharmacy Nomination** | |
| All prescriptions will go electronically to your nominated local pharmacy, please provide details | |
| Nominated Pharmacy: |  |

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| **3. Your Lifestyle** |

|  |  |
| --- | --- |
| **Alcohol Consumption** | |
| Number of units per week |  |
| How often do you drink? |  |
| (small glass wine = 1 unit, 1 pint of beer = 2 units, 1 pub measure of spirit = 1 unit) | |

|  |
| --- |
| **3. Your Lifestyle - Continued** |

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

|  |  |  |  |
| --- | --- | --- | --- |
| **Height & Weight** | | | |
| Height |  | Weight |  |
| Waist Circumference |  | BMI |  |
| **Women Only** | | | |
| Do you use any contraception? | | Yes  No | |
| Do you have a coil or implant? | | Yes  No Date inserted:………………………. | |
| Are you currently pregnant or think you may be? | | Yes  No Expected due date:………………… | |

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| **3. Access** |

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| **Summary Care Record –** Please read the attached NHS Summary Care Record information | |
| Do you want summary care record | Yes  No |
| Signature | ……………………………………….. |

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| --- | --- | --- | --- | --- | --- | --- |
| **Online Access** | | | | | | |
| Village Surgery provides its patients with the ability to use online access. If you have provided the practice with a valid email address for online access, you can –  **Request/ order medication / View summary / Coded / Full Record** | | | | | | |
| If you would like access online through SystmOnline please sign below, your identification will be checked during registration, you will receive an email at a later stage with your username and password. | | | | | | |
| Signature | ……………………………………………. | | | Date | | …………………… |
| Email Confirmation | ………………………………………………………………………………………….. | | | | | |
| Online access is only accessible for patients aged 16 +. | | | | | | |
| Reception use only | | | | | | |
| Identification checked by: | |  | Date: | |  | |