**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**

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| **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 [ ]  NoIf 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*

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| **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** |

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| **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: |

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| **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 highlightFH: 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 belowPlease 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** |

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| **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) |

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| **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) |

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| **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: |  |