PARKSIDE MEDICAL PRACTICE
NEW PATIENT INFORMATION
(MUST BE COMPLETED BY PATIENT BEFORE REGISTRATION)

This Practice, in line with other health care providers, collects information about the ethnic group that patients feel they belong to. In completing this form you will be helping us to help you, by helping us to plan and deliver a better service to our patients and ensure everyone has equal access to the health care we provide. This information is completely confidential at all times.

Patient Name:…….Date of Birth:…….

Address: …….. ……

Post Code:……..... Telephone No:……..…….....

What is your country of birth? ……..

What is your religion?.....

Marital Status (please tick)

Single	**Married**	**Common Law Partnership**	**Widowed**
Separated	**Divorced**	**Other**	

To Which Ethnic Group do you belong? (Please tick)

□	British or Mixed British	Irish	□
□	Other White background	White and Black Caribbean □	□
	White and Asian	White and Black African	□
□	Other Mixed background	Indian or British Indian	□
□	Pakistani or British Pakistani	Other Asian background	□
□	Bangladeshi or British Bangladeshi	Caribbean	□
□	African	Other Black background	□
□	Chinese	Other	□

Occupation (please tick)

Employed	**Self Employed**
Retired	**Unemployed**
Student	**Other**

What is your main spoken language? …….

Do you require an interpreter? YES □ NO □

Do you require an interpreter for British Sign Language? YES □ NO □

(MUST BE COMPLETED BY PATIENT BEFORE REGISTRATION)

I consent to the practice contacting me by text message for the purposes of health promotion and for appointment reminders. Your DOB may be on the text messages.

I acknowledge that appointment reminders by text are an additional service and that these may not take place on all / or on any occasion, and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time.

The surgery does not offer a reply facility to enable patients to respond to texts directly. Text messages are generated using a secure facility. The practice will not transmit any information which would enable an individual patient to be identified. However I understand that text messages are transmitted over a public network onto a personal telephone and as such may not be secure.

NAME	
D.O.B	
MOBILE NUMBER	
HOME TELEPHONE NUMBER	
EMAIL ADDRESS	
DATE	
SIGNATURE	

OFFICE USE ONLY		**INITIAL WHEN ADDED TO MRE**
Consent given for communication by SMS text messaging	**XaQid**	
Declined consent for short message service text messaging	**XaQmZ**	

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As part of our aim to improve patient care services you can now choose to SHARE your Summary Care Record with NHS service providers: This will only include medication, operations, long term illnesses and allergies: For further information please ask our receptionists.

I WANT A SUMMARY CARE RECORD ☐ I DO NOT WANT A SUMMARY CARE RECORD ☐

At times we may be required to share your medical information with other teams providing your care. Please indicate that you are happy for us to share your information from the surgery and with other care providers

I AGREE TO SHARE MY MEDICAL RECORD WITH APPROPRIATE SERVICE PROVIDERS ☐
I DO NOT WANT TO SHARE MY MEDICAL RECORD ☐

Your Height: …… Your Weight: …… Your BMI.....

Do you have any Allergies?

……

Serious Illnesses/Disability: e.g.Diabetes/Asthma/COPD/Hypertension/Blind/Learning Disability/

……

……

Current REPEAT medication:

…….....

……

PLEASE MAKE AN APPOINTMENT WITH THE PRACTICE PHARMACIST AS SOON AS POSSIBLE IF YOU HAVE A NUMBER OF REPEAT MEDICATIONS AND BRING YOUR MEDICATION WITH YOU TO YOUR APPOINTMENT

Do you have a 'Carer'? YES ☐ NO ☐

Do you care for another person? YES NO ☐

If YES please ask receptionist and complete a Carers Blue card.

Female Patients: 25 – 65 yrs of age:

Date of Last Smear: ……..…..

Are you able to communicate your needs and wishes? YES NO

What is your preferred method of contact ?.....

(MUST BE COMPLETED BY PATIENT BEFORE REGISTRATION)

Do you smoke tobacco/pipe/other? Circle one of the following:

SMOKER ☐ EX SMOKER ☐ NEVER SMOKED ☐

If you are a smoker and you want support to help give up, you can always ask our reception team to book an appointment for you here at the surgery.

PLEASE ENSURE YOU BRING YOUR VACCINATION HISTORY WHEN YOU ATTEND THE SURGERY TO REGISTER.

Do you drink Alcohol? YES ☐ NO ☐

If YES how many units per week? …….
(1 Unit = half pint of alcohol or 1 pub measure of spirit)

ETP – Electronic Transfer of Prescriptions

I consent to the practice sending my medication to the following pharmacy
Name of pharmacy …….

Patient signature…….. Date…….

How many people live at your address, please write their name, DOB, and relationship.

NAME	D.O.B	RELATIONSHIP