**ALTON SURGERY**

**HURSTONS LANE,**

**ALTON,**

**ST10 4AP**

**Phone: 01538704200 Email: altonsurgery@nhs.net**

**New Patient Registration**

**About you**

Surname: …………………………………… Forename(s): …….…………………………………

Date of Birth (dd/mm/yyyy): ………………. NHS number (if known): ………………………….

Gender: …………………………………… ([www.nhs.uk/find-nhs-number](http://www.nhs.uk/find-nhs-number))

**Contact Information**

Address:…………………………………………………………………………………………………

Telephone: ……………………………………… Mobile:……………………………………………

Email: ………………………………………………

Please circle below your preferred choice of contact:

**Text Phone Email Post**

**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:

|  |  |  |  |
| --- | --- | --- | --- |
| **I AM** a Military Veteran |  | **I AM** currently serving in the Reserve Forces |  |
| **I AM** married/civil partnership to a serving member of the Regular/Reserve Armed Forces |  | **I AM** married/civil partnership to a Military Veteran  |  |
| **I AM** under 18 and my parent(s) are serving member(s) of the armed forces. |  | **I AM** under 18 and my parent(s) are veteran(s) of the armed forces. |  |

**Asylum Seekers**

Are you classed as an Asylum seeker? **YES NO**

If so, please indicate your country of origin:……………………………………………

**Country of birth**

In which country were you born?...........................................................

If you are from abroad, what date did you come to UK?............................................................

**Main language**

What is your main spoken language?.................................................................

What is your preferred written language?.............................................................................

Do you need an interpreter? **Yes No**

 If so, which language? …………………………………………

**Carer status**

Do you have a carer? **Yes No**

**If Yes, please give details of their name, relationship and whether they are a patient here too………………………………………………………………………………………………………..**

Do you give consent for us to contact your carer about your care? **Yes No**

Are you yourself a carer? **Yes No**

**Next of kin**

Surname: …………………………………… Forename(s): …………………………………………

Gender: …………………………………… Relationship to patient ……………………………………

**Emergency contact Information (for next of kin)**

Telephone: ……………………………………… Mobile: ……………………………………………

**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 messages to you by email? **Yes No**

Do you consent to the Surgery leaving messages on your phone? **Yes No**

(We will not leave detailed messages on your phone, but may ask you to contact us or leave a simple message if we do not need to speak to you).

**Summary Care Record (SCR)**

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. Your Summary Care Record will also include your name, address, date of birth and your unique NHS Number to help identify you correctly.

**For more information**: visit <https://digital.nhs.uk/services/summary-care-records-scr>

Please select one of the following options

1. **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies and adverse reactions only.
2. **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.
3. **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

**Local Shared Electronic Health Record**

Many areas of the country have a local shared electronic health record too. 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. You can find out more information at <https://www.twbstaffsandstoke.org.uk/about-us/our-work/one-health-and-care/>

Are you happy to be part of the local shared electronic health care record?

(If you select no, you need to be aware that NHS Healthcare staff may

not be able to see important elements of your care history)

 **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 (e.g. hearing difficulties)?

**Yes No**

**If yes,** please state your needs below:

**………………………………………………………………………………..**

Do you have significant mobility issues? **Yes No**

Are you blind/partially sighted? **Yes No**

Do you have significant problems with your hearing? **Yes No**

**Family History and past medical history**

Have any close relatives ever suffered from any of the following (if yes please detail the relationship)?

|  |  |  |
| --- | --- | --- |
| Condition | Yes | No |
| Heart Disease (Heart attack/Angina) |  |  |
| Stroke |  |  |
| Diabetes |  |  |
| Asthma |  |  |
| Cancer |  |  |

Do you have any current medical conditions?

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Allergies**

Please list any drug or food allergies that you have:

…………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

**Medications**

Please provide a list of repeat medications:

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………