

**Welcome to Beechwood Surgery**

**For Receptionist use only**

**16 Years & Over**

1. **New Patient checklist before registrations can be accepted. Do not accept incomplete registrations, if incomplete as the patient to return with the required information.**
* Please check NHS number, DOB, Address (both past and present) [ ]
* Previous surname if the patient has the title of MRS [ ]
* Date of Entry to UK if coming from abroad [ ]
* Telephone contact numbers [ ]
* Place of birth (TOWN not hospital) [ ]
* Has the patient signed the Purple GMS1 form? [ ]
* Has the patient signed the donor section? (if they have ticked any part of this section) [ ]

1. ID checked – if available [ ]

1. Nominate a pharmacy (page 6) [ ]

1. Opt out of the Summary Care Record scheme - please add (page 10)[ ]
2. Alcohol screening form – please add (page 7) [ ]

**HAVE ALL SECTIONS A – E HAVE BEEN COMPLETED?** [ ]

Form completed by (please print name)………………………………………..

**ONCE THIS FORM HAS BEEN CHECKED PLEASE LEAVE IN THE REGISTRATION TRAY**

**THANK YOU**

**Beechwood Surgery**

**Pastoral Way, Warley, Brentwood, CM14 5WF**

**Tel: 01277 212820**

**www.beechwood-surgery.co.uk**

**1.) BACKGROUND DETAILS**

**CONTACT DETAILS - *\* It is your responsibility to keep us updated with any changes to your contact details***

| First name |  |
| --- | --- |
| Surname |   |
| Former surname |  |
| Address |  Post code: |
| Date of birth |  Male or Female: |
| Mobile number |  Text message consent: Y N This will be used to confirm appointments and other important communications. |
| Home contact number |  Home answerphone message consent: Y N |
| Email address |  Email contact consent: Y N |
| Country/Town of Birth |  |
| Family registered here? |  Y N |
| Next of Kin | Name: Telephone: Relationship to you: |

**ETHNIC GROUP (please tick):**

| White(British)  |  |  Black British |  | Asian British |  | Pakistani |  |
| --- | --- | --- | --- | --- | --- | --- | --- |

| White(Irish) |  | Black Caribbean  |  | Bangladeshi |  | Chinese |  |
| --- | --- | --- | --- | --- | --- | --- | --- |

| White(other) |  | Black African |  | Indian |  | Other |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |

Please state …………………………………………………..

**COMMUNICATION NEEDS**

| Language | What is your main spoken language? .................................................................. |
| --- | --- |
| Do you need an interpreter? Yes No  |
| Communication | Do you have any communication needs? (If **YES** please specify below) Yes No Hearing aid Large print British Sign Language Lip reading Braille Makaton Sign Language Guide dog |

**EMPLOYMENT**

| Employed  |  | Student  |  |
| --- | --- | --- | --- |
| Self‑employed |  | Unemployed |  |

**Occupation (if applicable):………………………………………………………………………………….....**

**CARER DETAILS**

| Are **YOU** a carer? | Yes – informal/unpaid carer Yes – occupational/paid carer |
| --- | --- |
| Do you **HAVE** a carer? | Yes  | Name\*: | Tel: | Relationship: |

\*Only add a carer’s details if they give their consent to have these details stored on your medical record

**2.) MEDICAL HISTORY**

**ILLNESSES – do you suffer from or have suffered from (please tick box)**

| Diabetes (please state type I or II) |  | Epilepsy |  | Asthma |  | COPD |  | Hypertension |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |

| Stroke |  | Glaucoma |  | Tuberculosis |  | Any other long term illness: |  |
| --- | --- | --- | --- | --- | --- | --- | --- |

| Cancer |  | Please specify: | Heart problems: |  | Please specify: |
| --- | --- | --- | --- | --- | --- |

Other (please state):

**FAMILY HISTORY**

Please tick any significant family history of close relatives with medical problems **and confirm which relative e.g. mother, father, brother, sister, grandparent**

| Medical condition | Relative |
| --- | --- |
| Asthma |  |
| COPD  |  |
| Epilepsy |  |
| Thyroid | Under/overactive (please circle) |  |
| Diabetes/type | Type I or Type II (please circle) |  |
| Liver disease |  |
| Heart disease |  |
| Stroke |  |
| High BP |  |
| Cancer |  (Please also state type)  |  |
| Kidney disease |  |
| Depression |  |

 Other (please state below)

………………………………………………………………………………………………………………………………………………………………………….............

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**ALLERGIES (please specify):**

| Please record any allergies or sensitivities below: | Symptoms: |
| --- | --- |

| **PRESCRIPTIONS** Please name the pharmacy you would like to collect your prescriptions from: |
| --- |
| Pharmacy: |

**CURRENT/REPEAT MEDICATION – Please provide a copy of your repeat prescription from your previous GP if possible.** Please state below including dose and frequency if known:

**3.) LIFESTYLE**

|  |
| --- |
| **Alcohol: Please answer the following questions which are validated as screening tools for alcohol use.** |
|  |
| **AUDIT–C QUESTIONS** | **Scoring System** | **Your Score** |
| **0** | **1** | **2** | **3** | **4** |
| 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 |  |
| 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+ |  |
| 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  |  |
| A score of **less than 5** indicates *lower risk drinking***.** |  TOTAL: |  |

**Scores of 5 or more requires the following 7 questions to be completed:**

|  |  |  |
| --- | --- | --- |
| **AUDIT QUESTIONS**(after completing 3 AUDIT-C questions above) | **Scoring System** | **Your Score** |
| **0** | **1** | **2** | **3** | **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 |  |
| 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 |  |
| 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 |  |
| 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 |  |
| 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 |  |
| Have you or somebody else been injured as a result of your drinking? | No |  | Yes, but not in last year |  | Yes, during last year |  |
| 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 last year |  | Yes, during last year |  |
|  |  TOTAL: |  |



**3.) LIFESTYLE (CONTINUED)**

| Height (cm) : |  |  Weight (kg): |  |
| --- | --- | --- | --- |

**EXERCISE HABIT:**

| None |  | Light |  | Moderate |  | Heavy |  | Regular |  | Please specify: |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |

| **SMOKING** |
| --- |
| Do you smoke? | Never smoked Ex-smoker Yes |
| How many cigarettes did/do you smoke each day? | Less than one 1-9 1 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),or call Essex Lifestyle Service: 0300 303 9988 |

**THE PRACTICE DOES NOT OFFER A QUIT SMOKING PROGRAMME – PLEASE SEE ABOVE OF HELP IF IT’S REQUIRED.**

| **Students Only:** |
| --- |
| Students are at risk of certain infections, including mumps, meningitis and sexually transmitted infections, as well as mental health issues including stress, anxiety and depression.Please see www.nhs.uk/livewell/studenthealth |

**WOMEN ONLY:**

**Do you use any contraception? Yes No**

**If yes, please tick:** Barrier (condoms) Oral contraceptive pill Implant

 Coil Injection

If needed, please book appointment

**Are you currently pregnant?** YES NO Unsure

**Date of last cervical smear:**

**Have you ever had an abnormal smear result?** YES NO Details: Date:

**Number of pregnancies** (please include any miscarriages or terminations)

| **Organ and Blood Donation** |
| --- |
| NHS Organ Donor RegisterTo register your details on the NHS Organ Donor Register please go to: [www.organdonation.nhs.uk](http://www.organdonation.nhs.uk/)NHS Blood Donor RegisterTo register your details on the NHS Blood Donor Register please go to: [www.blood.co.uk](http://www.blood.co.uk/)  |

**BP READING:**

**4.) SHARING YOUR HEALTH RECORD (Summary Care Record)**

This will be created as part of you registration and can be used in emergency care anywhere in England with you permission. If you require further information please ask at reception.

| Name |  |
| --- | --- |
| Date of birth |  |

**YOUR HEALTH RECORD**

| Do you consent to your GP practice sharing your health record with other organisations who care for you? |
| --- |
| Yes *(recommended option)*No *(not recommended, please discuss this with your GP before ticking this option)* |
| Do you consent to your GP practice viewing your health record from other organisations that care for you? |
| Yes (recommended option)No |

**NEW PATIENT CHECKLIST (FOR PATIENTS TO COMPLETE):**

**Please tick all the boxes below to confirm you have completed and understood the requirements for new patients so that your registration can be completed successfully:**

|  | Completed and signed New Patient Questionnaire |
| --- | --- |
|  | Completed and signed GMS1 form |
|  | Photo proof of ID *(e.g. passport, photo driving license or photo ID card)* |
|  | Proof of address *(e.g. bank statement, utility bill or council tax from within the last three months)* |
|  | If you are on repeat medication please ensure you have at least 30 days of medication from your current surgery and ensure you make an appointment with a GP before you put in a new prescription request with us (please tick to confirm you understand this even if you do not have any repeat medication) |

| **SIGNATURES** |
| --- |
| I confirm that the information I have provided is true to the best of my knowledge. |
| **Signature** |  | Signed on behalf of patient |
| **Print name** |  |
| **Date** |  |

**5.) ONLINE ACCESS**

Please read information **overleaf** before completing this form.

| Name |  |
| --- | --- |
| Date of birth |  |

**YOUR HEALTH RECORD**

| Do you consent to your GP practice sharing your health record with other organisations who care for you? |
| --- |
| Yes *(recommended option)*No *(not recommended, please discuss this with your GP before ticking this option)* |
| Do you consent to your GP practice viewing your health record from other organisations that care for you? |
| Yes (recommended option)No |

**All new patients will be given access to the following services:**

1. Booking Appointments
2. Requesting repeat prescriptions
3. Access to my coded\* medical records

\*Contains any medical codes that have been recorded)

**Application for online access to my medical record**

I wish to access my medical record online and understand and agree with each statement (please tick)

1. I have read and understood the information on the leaflet attached to this form 
2. I will be responsible for the security of the information that I see or download 
3. If I choose to share my information with anyone else, this is at my own risk 
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
5. If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible 

If you are registering children under 12 please tick that you would like to have access to their record at the same time as your own 

| Print name: |  |
| --- | --- |
| Signature: |  | Date: |  |

### For practice use only : Coded: Xabui / Registered for online access. XaeEr / Declined online access.

|  Identity verified through(tick all that apply) | Vouching 🞏 Photo ID 🞏 | Name of verifier | Date |
| --- | --- | --- | --- |
| Name of person who authorised (if applicable) |  | Date |

**ONLINE ACCESS**

Online access gives you the ability to view your medical record and test results, as well as order prescriptions and book appointments.

If you would like to apply for this now, please read the information overleaf and then sign the attached application form.

**Important Information – please read before signing attached form**

If you wish, you can now use the internet to book appointments with a GP, request repeat prescriptions for any medication you take regularly and look at your medical record. You can still use the telephone to call in to the surgery to book appointments as well. It’s your choice.

**It will be your responsibility to keep your login details safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.**

If you can’t do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

**If you print out any information from your record, it is also your responsibility to keep it secure. If you are at all worried about keeping printed records safe, we recommend that you do not make copies at all.**

**Before you apply for online access to your record, there are some other things to consider.**

Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details:

| **Forgotten history**There may be something you have forgotten about in your record that you might find upsetting. |
| --- |
| **Abnormal results or bad news**If your GP has given you access to test results or letters, you may see something that you find upsetting. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them. |
| **Choosing to share your information with someone**It’s up to you whether or not you share your information with others – perhaps family members or carers. It’s your choice, but also your responsibility to keep the information safe and secure. |
| **Coercion**If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time. |
| **Misunderstood information**Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery. |
| **Information about someone else**If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible. |

**More information**

For more information about keeping your healthcare record safe and secure, you will find a helpful leaflet produced by the NHS in conjunction with the British Computer Society: Keeping Your Online Health and Social Care Records Safe and Secure <http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf>