New Patient Registration Form

Do you have special communication needs? If yes,

Sign Language ☐ **Large Print** ☐ **Other** ☐

Thank you for choosing to join Hampstead Group Practice. You must complete this form accurately, USING BLOCK CAPITALS, as the information provided by you forms part of your medical record. If you have problems completing any section please ask at Reception for assistance. The information you provide is confidential and will be kept confidential.

Title (Mr./Mrs./Ms./Miss/Other)…… Male ☐ Female ☐

Surname……..First name(s)……..……..…

Calling/Preferred Name: …… Previous surnames (if any): ……..…

Date of Birth ……/……../…….. NHS No (if known)……
(day) (month) (year

Are you aged 40 or above Yes ☐ No ☐

IF YOU ARE AGED 40 OR ABOVE, YOU ARE REQUIRED TO HAVE A NEW PATIENT HEALTH CHECK AS PART OF THE REGISTRATION PROCESS. AN APPOINTMENT WILL BE MADE FOR YOU BY THE RECEPTIONIST.

Address

Line 1……

Line 2……

Line 3……..……..

Postcode……..

Contact details

Home Telephone……..……

Mobile Telephone…….……...

Work Telephone……..…….

Email…….……
Please note, we may contact you by text message or email. Only include these details if you are happy to be contacted this way.

Person to be contacted in case of an emergency

Name……..… Contact Number…….……

What is your relationship to this person? ……..……..……

Personal Details

Your Religion……

Are you registered disabled? Yes ☐ No ☐

If yes please give details of your disability

…..……

What is your current occupation/profession?

……

Are you or have you ever been a member of the British Armed Forces? Yes ☐ No ☐

Carers

Carers are people who are look after a relative, friend, partner or neighbour who cannot manage on their own. The person they are caring for or supporting may be elderly or ill, have a disability, have learning difficulties or a mental health problem or be a child with special needs.

Are you a carer for someone? Yes ☐ No ☐

If 'Yes', are they registered at this Practice? Yes ☐ No ☐

Name of the person for whom you care: …….

Contact number for that person: ……

Do you have a Carer? Yes ☐ No ☐

If 'Yes', are they registered at this Practice? Yes ☐ No ☐

Name of the person who cares for you: ……..……..

Contact number for that person: ……..……

Online Access

Do you wish to have online access for booking appointment, requesting medication & accessing medical records?

Yes ☐ No ☐

Please note this service is currently only available for patients aged 16 and over.

Medical Details

Allergies (*to anything, including medicines)*

……..

……..

……..

……..

……..

…….

…….

Height: ……..…….

Weight: ……..……

Blood Pressure: …..……

Please ask at Reception for instructions on how to use the health pod if you are unsure of the answers to these questions.

Past Medical History

Please list any illnesses, operations or other serious medical problems that you have had in the past or have currently.	Date of Onset

Family History

Is there a family history of the following?	Yes/No	Immediate family member(s) (only include parents/brothers/sisters)	Age when first diagnosed
Heart attack, angina or bypass surgery			
High blood pressure			
CVA/Stroke/TIA			
Diabetes			
Asthma/COPD			
*Cancer			

*If 'yes' please give details of the site of the cancer:

Smoking
Smoking puts your health at risk, can shorten your life and cause serious illness.

Do you smoke? Yes ☐ No ☐ If yes, for how many years have you smoked? ……

If 'Yes' how many cigarettes do you smoke per day? ……

If 'No', have you ever smoked? Yes ☐ No ☐

If 'yes', how many cigarettes did you smoke per day? ……...

For How many years did you smoke? ……

Please tick this box if you would like an appointment with a smoking cessation adviser ☐

Sexual Health

We offer all new patients testing for HIV and hepatitis, on request. Many people with blood borne viruses such as HIV and hepatitis B and C are unaware that they are infected. Knowing your status means you can access treatments to keep you fit and healthy and reduce the risk of complications and transmission. If you wish to be tested, please make an appointment at Reception.

Please tick this box if you would like us to send you the screening test request forms ☐

Chlamydia Screening

Free chlamydia testing is available to men and women under 25 who have ever been sexually active. Testing for chlamydia is done with a urine test or a swab test so you don't always need a physical examination by a nurse or doctor. There is no need for a referral; free self-testing kits are available at reception.

Please tick this box if you would like the receptionist to offer you the self-testing kit ☐

Alcohol Use
Alcohol should only be consumed in moderation. Excessive consumption can lead to health problems.

1. How often do you have a drink containing alcohol?

Never ☐ Monthly ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week ☐

2. How many standard drinks* containing alcohol do you have on a typical day when you are drinking?

1-2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 or 8 ☐ 10 or more ☐

3. How often do you have 6 or more standard drinks* on one occasion?

Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily ☐

4. How many standard drinks of alcohol do you estimate you consume each week? ……

5. Please tick this box if you would like to book an appointment with our alcohol worker because of concerns you or your family may have over your drinking. ☐

*A standard drink of alcohol (around 10mls or 8g) is contained in:

- A single (25mls) pub measure of spirits
- Half a pint of normal strength beer or lager
- A small (85 ml) glass of standard strength wine (12%)

How did you hear about our Practice e.g. web search, NHS choices, word of mouth?

……

Signature…….. Date ……

Consent for contact by text and email

At HGP, we are expanding our Patient Text Messaging Service to now include appointment reminders, test results, health promotion, invitations to take part in research studies (voluntary) and updates. Consent to use this service is required.

Further details can be found on our website www.hampsteadgrouppractice.co.uk

Please indicate:

I consent to be contacted by text and email ☐

- It is important that you notify the Practice at any time when you change either your mobile number or email address
- If you wish to withdraw this consent at any time in the future, you are free to do so. Please contact the Practice should this be the case.

I do not wish to be contact by text and email ☐

Signature: _____ Date: _____

For Office Use Only	
Form checked and fully completed?	Yes ☐ No ☐
Opt Out form completed?	Yes ☐ No ☐
Ethnicity form completed?	Yes ☐ No ☐
Online access requested?	Yes ☐ No ☐ Online access form given ☐
Named GP …… Patient informed.	Yes ☐ No ☐ Coded on EMIS ☐
Smoking cessation appointment required?	Yes ☐ No ☐ Appointment booked ☐ Details: ……
BBV test forms required?	Yes ☐ No ☐ Test forms will be posted to patient by Medical Admin.
Chlamydia self-testing kit given	Yes ☐ No ☐ N/A ☐
New Patient healthcheck appointment required	Yes ☐ No ☐ Appointment booked ☐ Details: ……
Alcohol advisor appointment required?	Yes ☐ No ☐ Appointment booked ☐ Details: ……
Practice leaflet given?	Yes ☐ No ☐
Receptionist's Name and Initials	……..

Place of birth recorded (including London Borough)……..

Date Registered……