**REGISTERING WITH THIS PRACTICE**

**Please retain this information for your own records**

Dear New Patient

Thank you for your enquiry about joining the practice; we have pleasure in attaching a

New Patient Registration Pack.

**NOTE: This practice DOES NOT prescribe Temazepam, Diazepam or Dihydrocodeine**

**unless there is a documented medical need for it.**

**If you have previously been removed from our registered list of patients due to**

**violent or unacceptable conduct or for continued Non Attendance at pre-booked**

**appointments it is unlikely you will be accepted back on to our list. If you wish to**

**discuss this then please ask to speak to the Practice Manager.**

**Please also check to ensure your permanent address of residency is within our practice registration area as we DO NOT accept registrations outside of the area as stated:**

* **Barton Seagrave**
* **Cranford**
* **Geddington**
* **Grafton Underwood**
* **Kettering**
* **Newton**
* **Thorpe Malsor**
* **Warkton**
* **Weekley**

All our surgeries are run on an appointment basis; if you cannot attend please cancel your appointment otherwise you will be at risk of removal from our practice list.

All Urgent on the day appointments will be with one of our Advanced Nurse Practitioners.

To complete the registration process we need each person to complete a GMS 1

Registration Form and a Health Questionnaire.

Please ensure you complete the forms as fully as possible to ensure your registration is

not delayed.

Please note that all applicants are asked to provide the following confirmation of

identification and residency at their stated address:

***Confirmation of Identity:***

* + Passport
  + Driving Licence [must be photo id style]
  + Birth Certificate

***Confirmation of Address:***

* + Utility Bill [mobile telephone bills will not be accepted]
  + Council Tax Statement
  + Bank Statement [not online]
  + Other: please state what you are providing

***Note: Registration will not be refused if you are unable to provide the above***

On registration you will be allocated a named GP. If you wish to know who your named GP is, please check with reception after you have been registered.

Please be aware that Medical cards are no longer issued.

Yours sincerely

C:\Users\Dawn Savage\Desktop\Signatures\DS Signature 3.jpg

Dawn Savage

Practice Manager

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DRYLAND SURGERY

New Patient Registration Form

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Please complete a separate form for each family member to be registered.

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| Full Name: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Mobile Number: | | | | | | | | | | | | | | | | | |
| Mr Mrs / Miss / Ms / Other…….. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Home Phone: | | | | | | | | | | | | | | | | | |
| Address and Postcode: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Date of Birth: | | | | | | | | | | | | | | | | | |
| Next of kin: | | | | | | | | | | | | | | | | | |
| Next of kin emergency contact Number: | | | | | | | | | | | | | | | | | |
| How is your next of kin related to you?: | | | | | | | | | | | | | | | | | |
| Email address: | | | | | | | |  |  | |  | | |  | | |  | |  | |  | | |  | |  | |  | |  |  | |  | |  | |  | |  |  |  | |  | |  |  |  |
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| Marital Status: | | | | | |  | | | | | | Gender | | | | | | | | Male | | | | | Female | | | | | NHS Number (if known) | | | | | | | | | | | | | | | | | |
| Previous Doctor Name & Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Previous Doctor Telephone No: | | | | | | | | | | | | | | | | | |
| Are you a British forces veteran? *(a veteran is someone who has served in the forces for at least 1 day)* | | | | | | | | | | | | | | | Yes | | | | | | | | No | | | | | | | If Yes, please provide date you retired: | | | | | | | | | | | | | | | | | |
| Please provide your Service or Personnel Number: | | | | | | | | | | | | | | | | | |
| Your Ethnic Origin:  (select one) | | | | | | | | | | White (Uk) | | | | | | | | | | | | | | | | | White (Irish) | | | | | | | | | | | White (Other) | | | | | | | | | |
| Caribbean | | | | | | | | | | African | | | | | | | | | | | | | | | | | Asian | | | | | | | | | | | Other Mixed Background | | | | | | | | | |
| Indian /  British Indian | | | | | | | | | | Pakistani /  British Pakistani | | | | | | | | | | | | | | | | | Bangladeshi /  British Bangladeshi | | | | | | | | | | | Other Asian Background | | | | | | | | | |
| Other Black Background | | | | | | | | | | Chinese | | | | | | | | | | | | | | | | | Other | | | | | | | | | | | Not Stated | | | | | | | | | |
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| Your main or 1st language Spoken / Understood  (select one) | | | | | | | | | | English | | | | | | | | Hindi | | | | | | | | | Gujurati | | | | | Urdu | | | | | | Bengali | | | | | | Punjabi | | | |
| Polish | | | Ukrainian | | | | | | | French | | | | | | | | German | | | | | | | | | Spanish | | | | | Other:  (Please Specify) | | | | | | | | | | | | | | | |
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| Your Religion: | | | | | C of E | | | | | | | | Catholic | | | | | | | | | Other Christian | | | | | | | Buddhist | | | | | | | Hindu | | | | | | Muslim | | | | | |
| Sikh | | | | | | | | Jewish | | | | | | | | | Jehovah’s Witness | | | | | | | No Religion | | | | | | | Other Religion (state) | | | | | | | | | | | |
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| **HEALTH AND LIFESTYLE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Physical Details: | | | | | | | | | | | | | | | | Height: | | | | | | | | | | | | | | | | | | Weight: | | | | | | | | | | | | | |
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| **Smoking** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you currently a smoker? | | | | | | | | | | Yes | | | | | | | | No | | | | | | | | | Have you ever been a smoker? | | | | | | | | | | | Yes | | | | | | No | | | |
| If **Yes**, how many cigarettes / cigars / ozs of tobacco do you smoke in a week? | | | | | | | | | | | | | | | | | |  | | | | | | | | | *If you are a smoker and want to stop, please contact the local smoking cessation services First for Wellbeing on Telephone Number*  *0300 126 5000* | | | | | | | | | | | | | | | | | | | | |
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| **Alcohol – How much do you drink? (AUDIT C)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Question** | | | | | | | | | | **0** | | | | | | | | **1** | | | | | | | | | **2** | | | | | **3** | | | | | | **4** | | | | | | **Score** | | | |
| How often do you have a drink that contains alcohol? | | | | | | | | | | Never | | | | | | | | Monthly or less | | | | | | | | | 2 – 4 times per month | | | | | 2 – 3 times per week | | | | | | 4+ times per week | | | | | |  | | | |
| How many standard alcoholic drinks do you have on a typical day when you are drinking? | | | | | | | | | | 1 - 2 | | | | | | | | 3 - 4 | | | | | | | | | 5 - 6 | | | | | 7 - 8 | | | | | | 10+ | | | | | |  | | | |
| How often do you have 6 or more standard drinks on one occasion? | | | | | | | | | | Never | | | | | | | | Less than monthly | | | | | | | | | Monthly | | | | | Weekly | | | | | | Daily or almost daily | | | | | |  | | | |
| **Scoring:** A total of 5+ indicates possible harmful or hazardous drinking  If you require advice regarding your alcohol consumption – please ask at reception | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Allergies:**  Do you have any allergies or have you had an adverse reaction? | | | | | | | | | | Yes *(please provide details to what and the reaction):* | | | | | | | | | | | | | | | | | | | | | | | | | | | | No | | | | | | | | | |
| **New Patient Medical:**  Every new patient will be offered a new patient medical with our Treatment Room services – please tick the box if you would like us to arrange this – you will be sent your appointment details to the mobile telephone number you have stated as part of your registration | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | |
| Improving access to the practice in relation to disability or sensory loss is important to us.  **Is your access restricted? Yes / No**  If **Yes**, what is the best form of communication for you? *(please tick or state below)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Induction Loop | | | | | BSL interpreter | | | | | | | | Disabled access | | | | | | | | | Limited mobility | | | | | | | Wheelchair access | | | | | | | Guide dog access | | | | | | Interpreter (language) | | | | | |
| Alternative format for information | | | | | Sight impaired | | | | | | | | Hearing impairment | | | | | | | | | Difficulty with Speech | | | | | | | Other (please specify): | | | | | | | | | | | | | | | | | | |
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| **YOUR MEDICAL HISTORY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Do you currently** suffer from any medical problems / conditions / illnesses / disease?  Please give brief details and approximate date. | | | | | | | | | | | | | | | | | | | | | | | | | | | Date | | | | |  | | | | | | | | | | | | | | | |
| **Have you had** any significant medical problems / diseases / illnesses / operations in the past?  Please give brief details and approximate date. | | | | | | | | | | | | | | | | | | | | | | | | | | | Date | | | | |  | | | | | | | | | | | | | | | |
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| **YOUR MEDICATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please list any tables, medicines or other treatments you are currently taking:  ***You can attach copy of your previous surgery’s repeat medication list if you prefer.*** | | | | | | | | | | Name of Medication | | | | | | | | | | | | | | | | | Dose | | | | | | | | | | | How often do you take it? | | | | | | | | | |
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| Are you able to administer your own medicines? | | | | | | | | | | Yes | | | | | | | | | | | | | | | | | No – please detail specific issues (e.g. swallowing, opening containers) | | | | | | | | | | | | | | | | | | | | |
| Name of Nominated Pharmacy for Electronic Prescribing: | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
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| **WOMEN ONLY:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| When was your last smear done? | | | | | | | | | | | | | | | | | | | | | | | | | | | Date: | | | | | | | | | | | | | | | | | | | | |
| What was the result of the smear? | | | | | | | | | | | | | | | | | | | | | | | | | | | Result: | | | | | | | | | | | | | | | | | | | | |
| Date of last mammogram  (if applicable) | | | | | | | | | | | | | | | | | | | | | | | | | | | Date: | | | | | | | | | | | | | | | | | | | | |
| Method of current contraception  (if applicable) | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |

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| **YOUR FAMILY MEDICAL HISTORY** | | | |
| **Family History**  Please tick any of the following that affect your Parents, Brothers or Sisters  *(tick all that apply and who it relates to)* | Diabetes | Heart Attack (age 60 or above)  Heart Attack (under age 60) | Cancer: (include type) |
| Stroke | Asthma | High Blood Pressure |

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| **OTHER IMPORTANT INFORMATION** | | | | | |
| **Are you Cared For?**  If so please state their name, address, phone no and sign here if you are happy for us to disclose information about your health to your Carer. | | **Carer Contact Details**  Signed:  Date: | | | |
| **Are you a Carer?**  If so, please state the name, address and phone number of the person you Carer for: | | **Person Cared For Contact Details** | | | |
| Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)? | | Yes / No | If “Yes”, please state their name / address / phone number: | | |
| **ONLINE & TELEPHONE COMMUNICATION SERVICES**  **(for patients over the age of 13 only)** | | | | | |
| **E-mail :** | | We only send out general information by email, never confidential information. We will email you our newsletter to keep you up to date on what’s happening at the practice and may occasionally e-mail you to ask if you would provide feedback to help us to improve services. If you **ARE HAPPY** for us to contact you by email please tick here (you can opt out / in easily in the future). | | | |
| **Text Messaging [SMS]:** | | The surgery uses SMS text messaging services to provide both confirmation of appointment booking and appointment reminders.  If you **ARE HAPPY** for us to contact you in this way please tick here (you can opt out / in easily in the future). | | | |
| **Online Services:** | | If you would like to book and cancel appointments, request your repeat prescriptions and be able to view a summary of your medical records on-line then please tick here  *N.B. please allow one week after submitting your registration documents, for security purposes you will then be required to come to the surgery with your identification documents to enable the receptionist to provide you with a username and password for this service.* | | | |
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| **Named Accountable GP**  The 2015-2016 GP contract in England extends the requirement to provide a named accountable GP to all patients, rather than just those over 75. The role of the named GP is to take responsibility for the co-ordination of all appropriate services and ensure they are delivered where required (based on the named GP’s clinical judgement) to each of their patients.  Every new patient registering with the practice will be advised of who their Named Accountable GP is and we will continue to encourage all our patients to see that GP wherever possible | | | | | |
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| **SHARING YOUR RECORDS WITH OTHERS**  The NHS would like to share your data with other in a number of ways [for further information please ask at reception to see our Privacy Statements].  Please answer the questions below so that we know how you wish us to share your data. | | | | | |
| **NHS Summary Care Records.**  This allows us to share some of your medical information such as your medications, drug sensitivities, and allergies with emergency care services. You do have the right to opt out of this, but we do urge you to allow the sharing of this vital information when needed in times of emergency treatment. This is UK wide. For further information please visit [www.nhscarerecords.nhs.uk](http://www.nhscarerecords.nhs.uk) or telephone the Summary Care Records Information Line on 0300 303 5678. If you do nothing, we will create a Summary Care Record for you. If you would like to opt out please download the form from the website above and, complete and hand in with your registration forms. If you choose not to have a Summary Care Record you can change your mind at any time by informing your GP Practice. | | | | | |
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| **SystemOne Electronic Patient Record**  We are one of many clinical facilities that use a secure computerised medical record system called SystemOne. Each facility’s records are separate, but because we use the same system, we have the ability to share your information with other care team on the same system in order to improve your care. These include services such as GP Out of Hours Services. But it is your choice whether we share your record with them, and if we can see their records. As your GP surgery, it’s vital we keep as complete a medical record for you as we can so we can treat you with full knowledge of all your medical information. You will be asked when you attend another SystemOne facility if you are willing to allow that facility to share their record with us:  Please be assured that your record would only be accessed when the need arise to support you appropriately and that all staff abide by the NHS rules and security regarding confidentiality: | | | | | |
| **Sharing Out:** | **Yes:**  *I would like to share my medical record with other SystemOne healthcare professionals* | | | **No:**  *I would not like to share my medical record with other SystemOne healthcare professionals* | |
| **Sharing In:** | **Yes:**  *I would like Dryland Surgery to see my medical record from other SystemOne units.* | | | **No:**  *I would not like Dryland Surgery to see my medical record from other SystemOne units.* | |
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| **National Data Opt-out Programme**  Information about your health and care helps the NHS to improve individual care, speed up diagnosis, plan local services and research new treatments.  As of the 25th May 2018, the strict rules about how this data can and cannot be used were strengthened. The NHS is committed to keeping patients information safe and always being clear about how it is used.  Please visit [www.nhs.uk/your-nhs-data-matters](http://www.nhs.uk/your-nhs-data-matters) or call 0300 303 5678 to find out more. You can **choose** whether your confidential patient information is used for research and planning | | | | | |
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| **Patient Participation Group**  The Practice is committed to improving the services we provide to our patients.  To do this, it is vital that we hear from people about their experiences, views, and ideas for making our services better.  By expressing an interest, you will be helping us to plan ways of involving patients that suits you.  It will also mean we can keep you informed of opportunities to give your views and update you with developments within the Practice.  If you are interested in getting involved, please tick the box below and we will arrange for a Practice Patient Participation Group Application Form to be sent to you: | | | | | |
| ***I am interested in becoming involved in the Practice Patient Participation Group (please tick the “Yes” box):*** | | | | | Yes |
|  | | | | | |
| **DECLARATION:**  I declare that I am / my child\* is entitled to NHS service because I have been or intend to be ordinarily resident in the UK for a period of 6 months or longer and I wish to register with Dryland Surgery.  Signature: Date:  If signing on behalf of someone please state your name and relationship to the patient: | | | | | |