Ivy Grove Surgery
New Patient Registration Form

Today's Date:

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

Full Name:						**Telephone Number:**		
Mr / Mrs / Miss / Ms / Other……..						**Work Number**		
Address and Postcode						**Mobile Number:**		
						E-mail Address:		
Date of Birth:		**Previous / Maiden Name if different:**				**Town & Country of Birth**		
Marital Status:		**Gender:**	**Male:**	**Female:**				
Occupation:								
Previous Address and Postcode								
Previous Doctor Name & Address						**Previous Doctor Telephone No.**		
						If applicable, date you first came to live in Britain:		
If returning from Armed Forces:		**Your Service or Personnel Number**				**Your Enlistment Date**		
Your height:	**Feet / inches**		**cm**	**Your weight:**		**Stones / lbs.**	**kg**	
Your Religion:	**C of E**	**Catholic**	**Other Christian (state)**			**Buddhist**	**Hindu**	**Muslim**
	Sikh	**Jewish**	**Jehovah's Witness**			**No religion**	**Other religion (state)**	
Your Ethnic Origin: (select one)	**White (UK)**		**White (Irish)**			**White (Other)**		
Caribbean	**African**		**Asian**			**Other Mixed Background**		
Indian / Brit Indian	**Pakistani / Brit Pakistani**		**Bangladeshi / Brit Bangladeshi**			**Other Asian Background**		
Other Black Background	**Chinese**		**Other**			**Ethnic Category not stated**		

Your main or 1st language Spoken / Understood: (select one)	English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi
Polish	Ukrainian	French	German	Spanish	Other: (Please Specify)	

Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)	Diabetes	Heart Attack	Heart attack under age of 60	Bowel Cancer	
	Breast Cancer		High Blood Pressure	Asthma	Stroke
	Thyroid Disorder		Any other important Family Illness?		

What immunisations have you had? (please tick all that apply)	Diphtheria	Measles	German Measles	Tetanus	Polio	MMR
	Whooping Cough		Pre-school booster	Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses		

Smoking, Alcohol Consumption and Exercise:					
Are you currently a smoker?	Yes	No	Have you ever been a smoker?	Yes	No
If so, how many cigarettes / cigars / tobacco do you smoke in a week?			How much alcohol do you drink in a week (Units)? *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)*		
If you are a smoker and want to stop, please ask for information about local smoking cessation services.					
How often do you exercise?	No. times per week		Type(s) of exercise:		

Your Medical Background:		
What illnesses have you had & When?		
What operations have you had and When?		
Do you have any medical problems at present?		
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)		
Are you able to administer your own medicines?	Yes	No – please detail specific issues (e.g. swallowing, opening containers)

Next of Kin Full Name	**Next of Kin Telephone Number:**
Next of Kin Address and Postcode	**Mobile Number:**
	Their relationship to you:
Is your Next of Kin also your Emergency Contact?	**YES / NO (delete as appropriate)**
Emergency Contract – Full Name (if different from above)	**Emergency Contact Telephone Number (Home and Mobile):**

Specific Needs: Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:		
Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):		
Are you an 'Assistance Dog' User?		
Please state any Physical disabilities you have:		
Please state any Mental disabilities you have:		
Please state any requirements you have to be able to access the Practice premises		
Please state any Religious or Cultural needs:		
Do you require the help of a Translator / Interpreter?		
Please state any allergies and sensitivities you have:		
If you are a Carer, please state the name / address / phone number of the person YOU care for:	**Person Cared For Contact Details:**	
If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer Contact Details:**	
	Signed: **Date:**	
Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	**Yes / No**	***If "Yes", can you please bring a written copy of it when registering at the Practice***
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:**

Women only:				
When was your last smear done?	Date	Was this at your GP's Surgery?	Yes	NO
What was the result of the smear?				
Date of last mammogram (if applicable):	Date	Method of contraception (if used):		
Do you wish to see a nurse in this practice for contraceptive services (including the pill, coil or cap)?			Yes	NO

You can now have Access to your records online.
This allows you to order repeat prescriptions and book/cancel appointments and view parts of your record online. If you are interested in registering for this service please ask the receptions for an application form

Would like to receive communications from the practice by email. Please bear in mind that email communication is not secure and it could be accessed by third parties.	YES / NO
Would you like to receive reminders of appointments and messages from the surgery by text (SMS)?	YES / NO

Summary Care Records.

The NHS are changing the way your health information is stored and managed.
The NHS Summary Care record is an electronic record of important information about your health.
It will be available to health care staff providing your NHS Care. An information pack has been provided.

Are you happy to have a Summary Care Record?	Yes	No	

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 services better.
By expressing your interest, you will be helping us to plan ways of involving patients within the practice It will also mean we can keep you informed of opportunities to give your views and keep you up to date with developments within the Practice.

Yes, I am interested in becoming involved in the Practice Patient Participation Group either in person or as a virtual member (As a virtual member you will only be contacted by email) (please circle the group you would like to be involved in)	IN PERSON VIRTUAL
Yes, I am interested in receiving an email copy of the Practice Newsletter every 3 months.	YES / NO
PLEASE TICK THIS BOX TO GIVE CONSENT FOR IVY GROVE SURGERY TO CONTACT YOU USING THE INFORMATON YOU HAVE PROVIDED ON THIS FORM	

Patient Signature:		Signature on behalf of Patient:	

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or see our website: www.ivy.gs

FOR OFFICE USE ONLY

PATIENT ADDED		INFORMED OF NAMED GP & CODED	
BASIC DEMOGRAPHICS		DONOR SECTION	
NEXT OF KIN &EMERGENCY CONTACT		DATED CARD & WALLET	
ALCOHOL FORM		COPIED REG FORM (GMS1)	
SCR		PATIENT IN N/HOME? TASK > JCC	