NEW PATIENT QUESTIONNAIRE

Please fill out the following sections of this questionnaire as fully as you can, in **BLOCK CAPITALS AND CLEARLY** and then hand it back to Reception. Any information supplied on this form is strictly confidential.

NEW PATIENT CHECK DATE _____ PROOF SEEN? YES / NO name of person registering :

Last name: …… First name: ……..

Date of birth: …….. Male/Female (circle one)

Other family members registered at the practice including parents (names/relationship) ……
……..

Ethnicity: White – British □ White – Other □ Black African □ Black Caribbean □

Asian – Indian/Bangladeshi/Pakistani/Chinese/Japanese/Korean/Other (please circle) □……..

Mixed - White British/Black African □ Mixed – White British/Black Caribbean □

Mixed – White/Asian □ Mixed – White/Black Other □

Mixed - Other □ …… Other (not specified) □ Rather not disclose □

Languages spoken: …….. English spoken: Yes / No (circle one)

Occupation: …… Marital Status (circle one): Single/Married/Divorced/Widowed

Telephone: (h)…… (w)…… (m)……

Email address: ……

Emergency contact: (full name/relationship): ……

Contact numbers: (h)…….. (w)…… (m)……..

Next of Kin: (full name / relationship): ……..

Contact numbers: (h)…….. (w)…… (m)……

Nominated pharmacy (for electronic prescribing): ……

Are you a carer (unpaid)? (please circle) Y/N If yes, for whom?.....

Do you have a carer? (please circle) Y/N If yes, please provide carer details (name/contact no) :

……

Medications: Please bring details of any medications / health issues to your Health Check Appointment with the Nurse.

Do you have any food or drug allergies (include reactions, if known)? .....
……

CHILDREN UNDER 5 YEARS OLD:

***VACCINATIONS*:** Please provide Red Book or attach copies of any overseas vaccination records.

CONSENT FOR INFORMATION SHARING

Please read below and tick ONLY if you have read and understood the information clearly. This decision is reversible at any time either by informing your doctor or at reception.

SYSTM ONE: IT CONSENT TO SHARE INFORMATION

If you are ever seen at another surgery, urgent care centre or hospital, anywhere in the country that uses the same IT system as us, this will allow your clinicians access to all your medical data and records. This is a good way to ensure that there is no delay in the doctors' access to your clinical information in case of an emergency, and will make your consultation easier. This information will never be shared for research purposes or to any third party.

I am happy to allow this information to be shared □

I do not want this information shared □

SUMMARY CARE RECORDS (SCR)

SCR is an electronic record that only allows the following three aspects of your records to be shared: allergies, adverse reactions and medications. This will make it easier for you to receive prescriptions from doctors outside the practice, should you require them. No other clinical data is uploaded.

I am happy to allow this information to be shared □

I do not want this information to be shared □

CARE.DATA

This is data that is used to produce statistics to monitor and improve national care being delivered to the NHS patients in general. The information is collected from GPs which will be linked to information from hospitals. This data includes details of health conditions such as diabetes, heart disease, cancer, high blood pressure etc. only in the form of codes. The data collected WILL NOT include codes that relate to any sensitive information such as sexually transmitted diseases, nor will it include any notes written by the GP.

I am happy to allow this information to be shared □

I do not want this information to be shared □

I confirm that the information provided in this form is true and accurate to the best of my knowledge.

Full name of patient (please print): ……

Date of birth of Patient: ……

Signed by: (Name of Parent/Guardian – if signing for Child under 16) ……

Signature: …… Date……