

New Patient Questionnaire- Welcome to Kirby Road Surgery!

*To our new patients aged between 40-75, we recommend you attend for an NHS Health Check. This will be arranged after successful registration at this practice.*

Personal information- for all ages

Mr Mrs Miss Ms (please circle the appropriate title)

Full name:

Address:

Gender: Male Female

Postcode:

Landline number: Mobile number:

Email address:

Any children? Yes/ No If Yes, how many?

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Date of Birth:

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NHS Number:

Town and Country of Birth:

If born outside the UK, please state the date you entered the country:

Are you a carer? Yes/ No Who for?

1. Next of Kin Name/ relationship:

Next of Kin contact number:

Next of Kin Address and Postcode:

1. Next of Kin Name/ relationship:

Next of Kin contact number:

Next of Kin Address and Postcode:

Ethnicity: (please circle the relevant ethnicity)

White: English Scottish Welsh Irish European Other:

Asian: Asian British Indian Bangladeshi Pakistan

Black: Black British Caribbean African

Other (please specify):

Religion (please specify):

First language (if not English):

Health Questions:

Do you have any allergies? Yes/ No If yes, please state allergy:

Are you a current smoker? Yes/ No If yes, how many a day?

Are you an ex- smoker? Yes/ No If yes, what date did you quit?

If yes to the above, how many cigarettes did you smoke a day?

What is your height? What is your weight?

Do you have any disabilities or special needs? This includes visual or hearing impairments:

For female patients, when was your last cervical screening?

For the following questions, please circle the answer that best applies.

(For reference, 1 drink (unit) = half a pint of beer/ lager OR 1 glass wine OR 1 single spirit).

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

Never Less than monthly Monthly Weekly Daily Almost daily

1. How many of units of alcohol do you drink on a typical day when you’re drinking?

1-2 3-4 5-6 7-8 10+

1. How often have you had 6 or more units if you’re female, OR 8 or more units if you’re male on a single occasion in the last year?

Never Less than monthly Monthly Weekly Daily Almost daily

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| --- | --- |
| Year | Details |
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Please provide a brief summary of your personal medical history:

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| --- | --- | --- |
| Name | Strength | Dose |
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Please provide a list of your current medications

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| --- | --- | --- |
| Condition | Y/N | Which family member |
| Heart disease |  |  |
| Diabetes |  |  |
| Cancer |  |  |
| High blood pressure |  |  |
| Cholesterol |  |  |
| Stroke |  |  |
| Asthma |  |  |

Do you have a family history of?

For ages 0-18 only.

Childs previous school:

Childs current school:

Child’s previous Health Visit:

Mother’s details: **Parent responsibility: Yes No**

Full name:

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Date of Birth:

Full and current address:

Telephone number:

Father’s details **Parent responsibility: Yes No**

Full name:

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Date of Birth:

Full and current address:

Telephone number:

Details of any other Primary carers:

Full name:

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Date of Birth:

Full and current address:

Telephone number:

Relationship to child:



Kirby Road Surgery’s Doctor/ Patient agreement.

In order to register at Kirby Road Surgery, you will need to read the practice’s doctor/ patient agreement below. You will then need sign at the end of the document to state that you have both read and understood this document and agree to adhere to our guidelines.

* Appointments are made for one person at a time. Please do not bring any other individual to see the GP unless they have their own booked appointment.
* Should you present to a GP with more than one issue (unless stated and documented beforehand) your GP may ask you to make another appointment to discuss these issues.
* Patient’s arriving more than 5 minutes late to an appointment may be asked to rearrange it.
* If you no longer need an appointment, please try to cancel it at least 24 hours prior to the appointment.
* Patients who fail to attend more than 3 appointments with a clinician will be deducted from our patient list
* Patients who make inappropriate use of emergency services when the surgery is closed will be removed from the patient list.
* Any complaints or suggestions should be put in writing to the practice manager.
* We have a zero-tolerance policy against rule and aggressive behaviour towards all members of staff. You will be removed from the list should you act in this way towards staff.

Signed:

Date:

Record sharing

An informed patient, in consultation with a Health Care Department Care Professional, can choose to permit or restrict access to the information entered into their records at each System One organisation that accesses their record. The patient will be asked to give their record sharing consent at each organisation at which they receive care. The patient’s consent can be changed at any time.

Sharing out:

Does the patient consent to the sharing of data recorded here with any other organisation that may care for the patient that use System One?

* Yes- share data with other organisations
* No- do not share any data recorded here

Sharing in:

Does the patient consent to the viewing of data by this organisation that is recorded at other care services that may care for the patient that use System One where the patient has agreed to make the data shareable?

* Consent given
* Consent refused

Full name:

Full address:

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| --- | --- | --- | --- | --- | --- |
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Date of birth:

Signed:

Date:

Application for online access to patient medical records.

Full name:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |

Date of birth:

Full address:

Postcode:

Email address:

Telephone number: Mobile number:

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| --- | --- |
| 1. Appointment booking |  |
| 1. Repeat prescription ordering |  |
| 1. Accessing my medical record |  |

I wish to have access to the following online services (please tick all that apply):

I wish to have access to my medical record online and understand and agree with each statement below (please tick all that apply and sign that you have understood):

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by Kirby Road Surgery |  |
| 1. I will be responsible for the security of the information that I access or download |  |
| 1. If I choose to share my information with any other individual, this is at my own risk |  |
| 1. If I suspect that my account has been accessed by someone without my prior consent, I will contact Kirby Road Surgery as soon as possible |  |
| 1. If I see information in my record that is inaccurate of not about me, I will contact the practise as soon as possible |  |
| 1. If I think that I may come under pressure to give an individual access to my account, I will contact the practice as soon as possible. |  |

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| --- | --- |
| Signature of patient: | Date: |

For Practice use only:

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| Patient NHS number: | | Practice computer ID number: |
| Identity verified by: | Date: | Identification check method (please tick which applies):   * Vouching * Vouching with information in record * Photo ID and proof of residence |

Authorised by: Date:

NHS Registration

In order for us to register you as a patient at Kirby Road Surgery, we are required to obtain evidence that you are entitled to NHS service and treatment. If you have lived in the United Kingdom for the last 6 months, you can provide utility bills, bank statements or a mortgage statement/ letter as proof of your address as well as your own country’s Health Card entitling you to receive health care in this country (equivalent to an EHIC card. We also ask that you provide a form of photographic ID, this can be a: driving licence, a provisional driving licence or a passport. If you have this, no further evidence will be needed. If you have been in this country less than 6 months, please answer the following questions and attach the form with your registration documents and Health Card to enable us to verify your eligibility.

1. Please give details of your full name, **previous** address and any previous GP surgery in the UK:
2. Your **current** address:
3. Where have you been residing for the past 12 months?
4. On what date did you arrive in the UK?
5. What country did you come from?
6. What is your purpose of your visit to the UK?
7. Is it your intention to reside in the UK permanently? If yes, please state why:
8. Can you provide that you have the right to remain in the UK (UK passport is not sufficient evidence)? If yes, you must provide documentary evidence of this i.e. Visa, entry clearance, Home Office correspondence etc). Persons from EEA countries and returning Nationals wishing to reside in the UK will be asked for proof relating to employment and residency.
9. On what date will you be leaving the UK?
10. Have you lived in the UK previously? If yes, please provide the dates:

Please return this form with your completed registration forms. Ensure you enclose any documentation that proves your right to free treatment e.g. your country’s Health Card for treatment abroad.