



COMMUNICATION NEEDS:

Do You have any special Communication Needs? Yes No

If 'Yes' Sign Language Large Print Other:.....

Accessible Information: If you have stated that you have any special communication needs on this form we will do our best to accommodate your needs. Should your needs change please inform us.

PERSONAL DETAILS:

Title: _____

Surname: _____

Given Name: _____

Middle Name(s): _____

Known As: _____

Previous Surname (where applicable): _____

Date of Birth: _____

NHS Number: _____

Gender: Male Female

Town+Country of Birth: _____

Marital Status: _____

Ethnicity: British African Bangladeshi Caribbean
 Chinese Indian Irish Other White
 Other Asian Other Black Other Mixed White Asian
 Pakistani W&B African W&B Caribbean Refuse to Divulge

Main Language: _____

Interpreter Required? Yes No

HOME ADDRESS:

House Name\Flat No.: _____

Street: _____

Locality: _____

Town: _____

Postcode: _____

CONTACT DETAILS:

Home Telephone: _____

Work Telephone: _____

Mobile Telephone: _____

Email Address: _____

Please tick here if you **DO NOT** give us permission to **TEXT** you, or leave you **VOICEMAIL** messages

The Adam Practice may wish to contact you via **email** regarding your results, appointments or other medical related issues. Do you give your consent to the practice to contact you via email containing confidential information?
 Yes No

PATIENT CONTACTS:

Next of Kin: _____

Relationship: _____

Telephone Number: _____

PLEASE HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING:

Previous address in the UK: _____

Name & Address of last GP: _____

Where were you last treated? : (e.g. GP surgery, walk-in centre, A&E etc)



IF YOU ARE FROM ABROAD: (PLEASE COMPLETE APPENDIX 1 - 'PATIENT DECLARATION')

First UK address where registered with a GP:	
If previously resident in UK date of leaving:	
Date you first came to live in the UK:	

IF YOU ARE RETURNING FROM THE ARMED FORCES:

Address before enlisting:			
Service or Personnel No.:			
Enlistment Date:		Date of Leaving:	

CARERS:

Are you a Carer? YES No

If YES, would you like to be added to the Practice's register to receive regular information and meeting dates YES No

(If yes) I care for (name):

Relationship to you:

The person I care for has: Dementia Physical Disability Mental Illness Chronic Disease

MEDICAL HISTORY:

Please tick all current or past illnesses/operations including dates where possible:

<input type="checkbox"/> Heart Disease / Angina	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> COPD
<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer	<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Dementia
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Other (please state):	

Do you have any Allergies? YES - Please state: No
(e.g. antibiotics, food, bee sting, latex)

Immunisations: If known, please circle the immunisation received and complete the date:

Vaccine	Date Received	Vaccine	Date Received
<input type="checkbox"/> Pneumococcal		<input type="checkbox"/> Polio	
<input type="checkbox"/> Tetanus		<input type="checkbox"/> Yellow Fever	
<input type="checkbox"/> Typhoid		<input type="checkbox"/> Hepatitis B	
<input type="checkbox"/> Hepatitis A		<input type="checkbox"/> MMR	

LADIES: Are you currently Pregnant? YES No

If you are pregnant please provide estimated delivery date:

HEALTH INFORMATION:

Weight: (st/lbs or Kgs)		Height: (ft" or metres)	
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Smoking Status: (please tick one box only)

I am a Smoker

(For help to stop smoking phone 0800 007 6653 or visit www.nhs.uk/smokefree)

I have never smoked I am an ex-smoker - Date quit:

Drinking:

Number of Alcohol units consumed per week;

Please complete the following questions:
(Alcohol 'FAST' screening test) **Screening test declined**

Scoring:	0	1	2	3	4	Total
How often do you have 8 (Men) or 6 (Women) or more drinks one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	

Only answer the following 3 questions on the next page if your score above is 2,3 or 4:

Scoring:	0	1	2	3	4	Total
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/clinician been concerned about your drinking/advised you to cut down?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
Total						

CURRENT MEDICATION:

If you have a repeat medication slip from your previous GP please attach to this form.

Electronic Prescription Service:

The practice can now send your prescription to your preferred pharmacy electronically. If you have previously nominated a pharmacy in another area and you now wish to change to a local pharmacy, please inform us of your new preferred pharmacy:

PRACTICE SERVICES / PATIENT GROUPS:

Would you be interested in joining our **Patient Participation Group (PPG)**? YES NO

Do you wish to register for the **SystemOnline** service? (Online prescriptions, appointment booking, view summary care record) YES NO

OTHER INFORMATION / PATIENT CONFIRMATION:

Declaration: In accordance with the Data Protection Act, the Practice needs consent from any Patient for us to leave a message, send a text or information regarding their medical treatment. By providing the information on this form you are consenting to be contacted about your medical needs by the practice. Also by completing and signing this form you are agreeing to abide by the details in the Adam Practice Patient Contract and Zero tolerance Policy (copies of which can be found on the practice website or requested from Reception). **If any of the details on this form change in the future please inform us.**

Signed:

Date:

Should you require any further information about the Practice please refer to the Practice Website: www.adampractice.co.uk or speak to Reception.

DATA SHARING – YOUR CONSENT AND CHOICES:

Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations/providers. To **OPT-OUT**, please ask a member of staff.

NHS DONOR REGISTRATION:

I wish to register my details on the NHS Organ donor &/or the NHs Blood Donor register(s) as someone whose organs/tissue may be used for transplantation after my death &/or someone who may be contacted and would be prepared to give blood.

For more information visit www.uktransplant.org.uk

I would like to donate: (Please tick all boxes that apply)

Any of my organs & tissue **or:** Any part of my body **or:**
 Heart only Liver only Corneas only
 Kidneys only Lungs only Pancreas only

I would like to join the Blood donor register: Yes No

I have given Blood in the last 3 years: Yes No

Signature confirming consent/agreement of items ticked above:

RECEPTION ONLY:


Type of ID Seen:	1.	2.
GP Allocated:	<input type="checkbox"/> YES <input type="checkbox"/> NO	Patient informed: <input type="checkbox"/> YES <input type="checkbox"/> NO
Actions completed & ID Seen by (initials):		

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Patient's details

Please complete in **BLOCK CAPITALS** and tick as appropriate

<input type="checkbox"/> Mr	<input type="checkbox"/> Mrs	<input type="checkbox"/> Miss	<input type="checkbox"/> Ms	Surname
Date of birth				First names
NHS No.				Previous surname/s
<input type="checkbox"/> Male <input type="checkbox"/> Female				Town and country of birth
Home address				
Postcode			Telephone number	

SUPPLEMENTARY QUESTIONS			
PATIENT DECLARATION for all patients who are not ordinarily resident in the UK			
<p>Anybody in England can register with a GP practice and receive free medical care from that practice. However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.</p> <p>Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.</p> <p><u>More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.</u></p> <p>You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.</p> <p>The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.</p> <p>Please tick one of the following boxes:</p> <p>a) <input type="checkbox"/> I understand that I may need to pay for NHS treatment outside of the GP practice</p> <p>b) <input type="checkbox"/> I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested</p> <p>c) <input type="checkbox"/> I do not know my chargeable status</p> <p>I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.</p> <p>A parent/guardian should complete the form on behalf of a child under 16.</p>			
Signed:		Date:	DD MM YY
Print name:		Relationship to patient:	
On behalf of:			
Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.			
NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS			
 <p style="font-size: small; padding-top: 5px;">If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.</p>	<p>Do you have a non-UK EHIC or PRC? YES: <input type="checkbox"/> NO: <input type="checkbox"/></p> <p>If yes, please enter details from your EHIC or PRC below:</p> <p>Country Code: <input type="text"/></p> <p>3: Name <input type="text"/></p> <p>4: Given Names <input type="text"/></p> <p>5: Date of Birth <input type="text" value="DD MM YYYY"/></p> <p>6: Personal Identification Number <input type="text"/></p> <p>7: Identification number of the institution <input type="text"/></p> <p>8: Identification number of the card <input type="text"/></p> <p>9: Expiry Date <input type="text" value="DD MM YYYY"/></p>	<p>PRC validity period (a) From: <input type="text" value="DD MM YYYY"/> (b) To: <input type="text" value="DD MM YYYY"/></p>	
<p>Please tick <input type="checkbox"/> if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). Please give your S1 form to the practice staff.</p>			
<p>How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.</p> <p>Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.</p>			