NEW PATIENT REGISTRATION PACK

Please complete all of the attached forms in order for us to process your registration.

After you have handed your registration form in to Reception, please call us approximately one week later in order to book your ‘New Patient Health Check’ with the nurse.

Please note that it is practice policy to call your name on the display board for appointments. If you do not want your name displaying on the call board, please sign an ‘opt out’ form at Reception.

Your registered named GP will be Dr Jaiveloo

New Patient Health Questionnaire

☐ Mr ☐ Mrs ☐ Miss ☐ Ms **Marital Status**……..……..

Name: _____ **Date of Birth:** _____

Weight: _____ **Height:** _____

Occupation: _____

Allergies: _____

SMOKING

Do you smoke? Yes / No If Yes, how many per day? _____

If yes, are you interested in stopping smoking? Yes / No

We can refer you to the Stop Smoking Service.

Tick here if you have never smoked ☐

EX-SMOKERS

If you used to smoke, how old were you when you stopped? _____

PASSIVE SMOKING

Are you exposed to smoke at work? Yes / No At home? Yes / No

EXERCISE

How many minutes do your exercise for at a time? ____ How many times per week? _____

FAMILY HISTORY

Is there any of the following in your family *(father, mother, brother, sister)* **before the age of 65?**

Heart Disease (Heart attacks, Angina)	Yes / No	Which family member? _____
Stroke?	Yes / No	Which family member? _____
Cancer? Site of cancer?	Yes / No	Which family member? _____
Diabetes	Yes / No	Which family member?_____

ETHNICITY

What is your main spoken language?

_____

Registration Form Ethnic Categories		Registration Form Ethnic Categories	
White British		Other White background	
African		Other Mixed background	
Bangladeshi or mixed British		White & Asian	
Caribbean		Pakistani or British Pakistani	
Chinese		White & Black African	
Indian or British Indian		White & Black Caribbean	
Other Asian background		Irish	
Other Black background		Other	

ALCOHOL - **PLEASE CIRCLE/TICK THE APPROPRIATE ANSWER.**

MEN: How often do you have EIGHT or more drinks on one occasion?
WOMEN: How often do you have SIX or more drinks on one occasion?

NEVER	LESS THAN MONTHLY	MONTHLY	WEEKLY	DAILY/ALMOST DAILY

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

NEVER	LESS THAN MONTHLY	MONTHLY	WEEKLY	DAILY/ALMOST DAILY

How often during the last year have you failed to do what was normally expected of you because of drinking?

NEVER	LESS THAN MONTHLY	MONTHLY	WEEKLY	DAILY/ALMOST DAILY

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

NO	YES ON ONE OCCASION	YES – ON MORE THAN ONE OCCASION

Text Message Consent Form

Name: _____

Date of Birth: _____

Mobile Number _____

Name of parent if number is for child record _____

I give consent for Laurbel Surgery to contact me via text message to inform me of the following:

- Appointment Confirmation
- Appointment Reminder
- Communication from the GP
- Health Promotions (E.G Seasonal Influenza Vaccination, Annual Review Invitation)

Your number will remain confidential and not be passed on to any third parties. We will not text you any confidential information

By signing below you are agreeing to keep your mobile number up to date with us and you also agree that we can text you in regards to the bullet points mentioned above.

Signed: _____

Date: _____

Record Sharing Consent Form

Name: _____

Date of Birth:_____

Sharing out

Information that can be shared with community services such as district nurses, physio, pain management etc

1. **Do you consent to the sharing of data recorded here with any other organisations that may care for you?**

☐ **Yes** - Share data with other organisations

☐ **No** - Do not share my data

Sharing In

Information that is held by community services who care for you, being immediately visible to the practice

2. **Do you consent for us to view data that is recorded at other care services who may care for you?** (In the case where you have agreed to make the data shareable)

☐ **Consent given**

☐ **Consent refused**

Signed: _____

Date: _____