Name: _____

# ARDEN MEDICAL CENTRE
# NHS PATIENT REGISTRATION (16+)

| **Patient Details** | | | |
|---|---|---|---|
| NHS Number: | | | |
| Title: | | Full Name: | |
| Previous Surnames: | | Country of Birth: | |
| Date of Birth: | | Marital Status: | |
| Address: | | | |
| Proof of Residency: | ☐ Driving Licence | ☐ Utility Bill | ☐ Bank Statement |
| Email: | | | |
| Occupation: | | Ethnicity: | |
| 1st Language: | | Religion: | |
| Mobile Number: | | Home Number: | |
| I consent to be contacted via text messages: | | ☐ YES | ☐ NO |

*The Practice may contact you by SMS text messaging with appointment details, advice/recalls about your health including invitations for vaccination or opening hours over holiday periods. To maintain confidentiality, **it is your responsibility to inform the Practice of changes to your mobile number**. If at any time you wish to opt out of receiving text messages, please contact us.

| | | |
|---|---|---|
| Do you have any communication needs? | ☐ YES | ☐ NO |
| If yes, details: | | |
| Please let us know if you would like this information in an alternative format. | | |

| **Carer Details** | | | | | | |
|---|---|---|---|---|---|---|
| A Carer provides help & support to a partner, child, relative, friend or neighbour, who could not manage without help. Carers may be paid or unpaid. We can offer you (as a Carer) or your Carer the correct help & support. | | | | | | |
| Are you a Carer? | ☐ YES | ☐ NO | Please contact us if support is needed. | | | |
| Do you have a Carer? | ☐ YES | ☐ NO | Please contact us if support is needed. | | | |
| If yes, Name: | | | Tel: | | Relationship: | |
| Only add carer's details if they give their consent to have these details stored on your medical record. | | | | | | |

Name: _____

| Medical History | | | | | | |
|---|---|---|---|---|---|---|
| Height: | | Weight: | | Blood Pressure if known: | | |
| Do you smoke? | | ☐ YES | ☐ NO | Have you ever smoked? | ☐ YES | ☐ NO |
| If yes, how many a day? | | | If yes, when did you quit? | | | |
| You can access smoking cessation help & advice through the local NHS Stop Smoking Service (Contact no: 0121 713 8918) or online at www.nhs.uk/smokefree. | | | | | | |
| Do you regularly feel troubled by the feeling of being nervous, anxious, irritable, afraid or not being able to stop worrying? | | | | | ☐ YES | ☐ NO |
| During the past month, have you been troubled by feeling low or depressed for much of the time? | | | | | ☐ YES | ☐ NO |
| During the past month, have you been troubled by not enjoying things you used to enjoy? | | | | | ☐ YES | ☐ NO |
| Have you suffered from any of the following conditions? | | | | | | |
| ☐ Asthma | ☐ COPD | ☐ Depression | ☐ Diabetes | ☐ Epilepsy | | |
| ☐ Heart Failure | ☐ High BP | ☐ Heart Disease | ☐ Kidney Disease | ☐ Thyroid | | |
| Any other conditions, operations or hospital admission details: | | | | | | |
| Any allergies: | | | | | | |

| Medication | | |
|---|---|---|
| Do you take any regular medication? | ☐ YES | ☐ NO |
| A medication review appointment with one of the doctors will be required before medication can be issued. Please list current medication and dosage below. Alternatively, **attach your current repeat list.** | | |

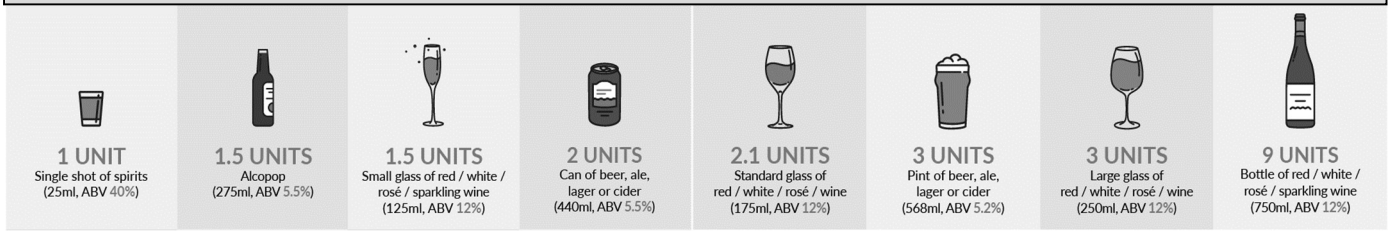
| Medication Name | Dosage |
|---|---|
| | |

| Electronic Prescribing Service | |
|---|---|
| If you would like your prescriptions to be electronically sent to a pharmacy, please give details of your chosen pharmacy: | |

| Family History | | | |
|---|---|---|---|
| Please give details of any illnesses which run in your family & give the relationship of the relative to you (e.g. mother) & their approximate age when they developed the condition. | | | |
| ☐ Asthma | ☐ Cancer | ☐ Cardiovascular disease | ☐ Depression |
| ☐ Diabetes | ☐ Hypertension | ☐ Hyperthyroidism | ☐ Glaucoma |
| ☐ Other Please Detail: | | | |

Name: _____

## Alcohol




| QUESTION | 0 | 1 | 2 | 3 | 4 | SCORE |
|---|---|---|---|---|---|---|
| How often do you have a drink that contains alcohol? | Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4+ times a week | |
| How many units of alcohol do you have on a typical day when you are drinking? | 1 - 2 | 3 - 4 | 5 - 6 | 7 - 8 | 9 + | |
| How often do you have 6 or more units on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily | |

**If total is more than 5, please complete the questions below.**

| QUESTION | 0 | 1 | 2 | 3 | 4 | SCORE |
|---|---|---|---|---|---|---|
| How often during the last year have you found that you were not able to stop drinking once you had started? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you failed to do what was normally expected from you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you had a feeling of guilt or remorse after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or 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 or almost daily | |
| Have you or somebody else been injured as a result of your drinking? | No | | Yes but not in the last year | | Yes, during the last year | |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No | | Yes but not in the last year | | Yes, during the last year | |
| | | | | | **TOTAL** | |

Name: _____

| **Named GP** | |
|---|---|
| You have a named GP who is responsible for generally overseeing your medical care. For your day to day consultations or if your named GP is not available you can continue to see any Doctor within the practice. | |
| **Date of Registration** | **Named GP** |
| Nov / Dec / Jan | Dr Clare Bailey |
| Feb / Mar | Dr Lucy Barnsley |
| Apr / May / Jun | Dr Harsha Dhokia |
| Jul / Aug / Sep / Oct | Dr Nomaan Ullah |

| **Sharing your Health Record** | | |
|---|---|---|
| The NHS stores and uses personal data in several ways in order to provide better, safer patient care. For more information about how your data is managed, please see our website at www.ardenmedicalcentre.co.uk<br>Please ensure you read this information before answering the following questions: | | |
| Do you consent to your GP Practice sharing your health record with other organisations that care for you? | ☐ YES | ☐ NO |
| Do you consent to your GP Practice viewing your health record from other organisations that care for you? | ☐ YES | ☐ NO |
| Do you consent to having an Enhanced Summary Care Record?<br>If you choose NOT to consent, please ask at reception for a Summary Care Opt-Out form. | ☐ YES | ☐ NO |
| I confirm that the information I have provided is true to the best of my knowledge. | | |
| Signature: | Date: | |

Name: _____

# ARDEN MEDICAL CENTRE
# ONLINE SERVICES APPLICATION

| **Online Services** | | | |
|---|---|---|---|
| Full Name: | | NHS Number: | |
| Date of Birth: | | Telephone: | |
| Email Address: | | | |
| Address: | | | |
| I wish to have online access to: | | | |
| ☐ Book appointments | | | |
| ☐ Request medication | | | |
| ☐ View my medical record (subject to policy) | | | |
| ☐ View my Summary Care Record | | | |
| ☐ Complete online questionnaires | | | |
| I wish to access my medical record & understand & agree with each statement below: | | | |
| ☐ I will be responsible for the security of the information that I see or download | | | |
| ☐ If I choose to share my information with anyone else, this is at my own risk | | | |
| ☐ I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement | | | |
| ☐ If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible | | | |
| Signature: | | Date: | |
| Print Name | | | |

| **For Practice Use Only:** | | | |
|---|---|---|---|
| ID Verified: | ☐ Vouching | ☐ Driving Licence | ☐ Passport |
| Initial of Verifier: | | Date: | |

**Before you apply for online access to your record, there are some other things to consider.**
**Forgotten history:** There may be something you have forgotten about in your record that you might find upsetting.
**Abnormal results or bad news:** If your GP has given you access to test results or letters, you may see something that you find upsetting. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them. If this happens, contact your surgery as soon as possible.
**Choosing to share your information with someone:** It's up to you whether you share your information with others, perhaps family members or carers. It's your responsibility to keep the information safe and secure.
**Coercion:** If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time.
**Misunderstood information:** Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.
**Information about someone else:** If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible.