Severnbank Surgery

Tutnalls Street, Lydney,
Gloucestershire GL15 5PF
Tel 01594 845715 Fax: 01594 845637

Patient's details
Mr☐ Miss☐

Surname……..…
Previous Surname……..……..…

Date of birth……
NHS Number……

First Names……..……..
(Known as……)

Town & Country of birth……..... ☐ Male ☐ Female
Please provide a copy of your FULL birth certificate
Home address……..
……
Post code…… Telephone number……..……
Mobile No: ……I give consent for Severnbank Surgery to contact me via my mobile and agree to notify them of any number change x……
Work No ……

Next of Kin
Name ……
Address ……
……Post code ……..
Telephone Number/s ……
Relationship to you ……..
Can we contact in your next of kin in an Emergency? Yes / No
Can we discuss your medical record with your next of kin? Yes / No

Carer Information
Are you a carer (Are you helping look after someone who is frail, ill or has a disability)?
Yes ☐ No ☐

If yes, please provide the details of the person for whom you care –
Name ……Relationship ……..
Address……..……..……
……Date of Birth ……
(Please sign below)

Do you have a carer (Is somebody helping to look after you due to frailty, illness or disability)?
Yes ☐ No ☐

If yes, please provide the details of the person who cares for you –
Name ……Relationship ……..
Address……..……..……
……Date of Birth ……
(Please sign below)

I agree to this information being held on your records. This practice has registered under the General Data Protection Regulation (GDPR) (EU) 2016/679

Signed: ……**Date** ……

Marital Status

Single (unmarried) □

Ethnic Group

British/mixed British	□	Bangladeshi/British Bangladeshi	□
Irish	□	Indian / British Indian	□
Other white background	□	Other Asian background	□
Caribbean	□	Other Black background	□
African	□	Other mixed background	□
Chinese	□	Other white background	□
White & Asian	□	Ethnic category not stated	□
White & Black African	□	White & Black Caribbean	□
Pakistani & British Pakistani	□	Other	□

First Language ……

If in full time education, School/college attended ……

Do you consider your health to be good? Yes □ No □

Do you have a clear idea about what sort of food is healthy? Yes □ No □

Do you exercise regularly? Yes □ No □

Have you ever smoked? Yes □ No □
If so, how many per day? ……

If you have stopped smoking, in which year did you stop? ……..
If you currently smoke, would you like help to stop smoking? ..... Yes □ No □

Smoking is the greatest single cause of illness and death in the UK. We have a support service to help you stop when you are ready. Please ask for an appointment with the Stop Smoking Nurse. You are five times more likely to succeed with help!

How many units of alcohol do you drink per week? .....
(one unit = 1 glass or wine, ½ pint beer or 1 measure of spirits)

How tall are you? …… **How much do you weigh**? ……

Do you take regular medication? Yes □ No □
If yes, please list, or if you have a repeat medication order slip, bring it with your application form so that the Doctor can add them to your computer record.

……. …….
……. …….

Are you allergic to any drugs? Yes □ (please list) No □
If so please list ……. …….
……. …….

This section is for completion by <u>female patients</u> only. Thank you.

Are you pregnant? …… Expected Date ……

Do you use contraception? Yes ☐ No ☐
If so which do you use?

Pill ☐ which one ……
Coil ☐ when was this fitted ……
Injection ☐ Date of last injection ……..
Condom ☐

Do you have any disabilities?
Yes ☐ (please explain) No ☐

……
……

Have you had any operations in the past?
Yes ☐ (please list below) No ☐

……..
……

Do you suffer with or do you have a close family history of any of the following:
(please tick any that apply)

	You	Family history
Asthma	☐	☐
Cancer	☐	☐
Diabetes	☐	☐
Glaucoma	☐	☐
Heart problems	☐	☐
High Blood Pressure	☐	☐
TB	☐	☐
Any other major illness ☐	☐	

(please explain) ……..

<u>Vaccinations</u>

Date of last Tetanus injection …….
Have you had any other travel immunisations?
If so, please list…….
…….
This section should be completed for patients under the age of 16 please.
Has the child had their…..

			Approx date
1st Immunisations	Yes ☐	No ☐	……
2nd Immunisations	Yes ☐	No ☐	……
3rd Immunisations	Yes ☐	No ☐	……
MMR	Yes ☐	No ☐	……
Preschool booster	Yes ☐	No ☐	……
14 yr Tetanus/diptheria booster	Yes ☐	No ☐	……
Meningitis C	Yes ☐	No ☐	……

I agree to bring my child for routine immunisation as recommended
X…… (signature of parent/guardian)

I consent to the information I have given on this application form being held on file under the terms of the General Data Protection Regulation (GPR) (EU) 2016/679 and I will provide evidence as proof of identity and permanent address if necessary

☐ **Signature of patient** ☐ **Signature on behalf of patient**

x…… **date**……

PATIENT INFORMATION SHARING AND CONSENT

All information you give to a member of the practice team is safeguarded by the General Data Protection Regulation (GDPR) (EU) 2016/679 and the NHS Care Record Guarantee. At all times, everyone working for the NHS has a legal duty to keep information about you confidential. However, information is sometimes shared where it is absolutely necessary to support your care or to help improve the service provided by the NHS. **You have a choice about whether your information is shared and for what purpose.** Please tick the boxes below to tell us what your choices are.

Summary Care Record A Summary Care Record contains information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had, to ensure those caring for you have enough information to treat you safely.	**Yes- a record will be created for you, but you can opt-out at any time.**	**No**
Do you want a Summary Care Record?	**Yes-** ☐	**No-** ☐

We encourage all patients over the age of 5 years to attend for a New Patient Registration appointment. This appointment should be booked with a Nurse if you are not taking regular medication and you are not worried about your health. You should ask for an appointment with a doctor for this check if you are concerned about your health or if you are taking regular medication. This appointment helps us to check your medical history. Please inform the receptionist if you would like to have this check.

Administration Section Only

FOR OFFICE USE ONLY

Allocated/Named GP: ……

Patient EMIS Number: ……

New patient check offered: Y ☐ N ☐

NPC offered 90W7 ☐ *Declined 90W2* ☐

Appointment booked: Date……Time……

Identity Verified: …… *ID Verified 91B2 Type of verification*

Patient Access Request

Patient Requested Online Access- Yes ☐ No ☐

Online Access Request Completed – ☐

Online Access Details Given- Printed ☐ Emailed ☐

Prescription Destination

Previous Prescription Destination removed (if applicable)- ☐

New Prescription Destination added (if applicable)- ☐