Severnbank Surgery

Tutnalls Street, Lydney,
Gloucestershire GL15 5PF
Tel 01594 845715

This form is for new patients under 16 only

Patient's details ☐
Mr☐ Mrs☐ Miss☐ Ms

Surname……

Previous Surname……

Date of birth……..
NHS Number……..
Town & Country of birth……...
……

First Names……..
(Known as……)
☐ Male ☐ Female

Home address……..
…… Post Code ……
Home Telephone number……..…… Work No……
Mobile No: ……
Email ……
Previous Home Address……
…….…….. Post Code ……..……
Previous GP Practice……..
I give consent for Severnbank Surgery to contact me via my mobile and agree to notify them of any number change- ☐

If coming from abroad, please tell us your first address in the UK where registered with a GP Practice……
……..
Date of first arrival in UK……
Date of leaving if previous UK resident……

Do you need Severnbank Surgery to dispense medication and appliances to you? *please note that not all doctors are authorised to dispense medication*

I live more than 1.6km in a straight line from the nearest chemist ☐
I would have serious difficulty in getting them from a chemist ☐

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 (GDPR) (EU) 2016/679 and I have attached evidence as proof of identity and permanent address

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

Signature……Date of Signature……..

Marital Status

Single ☐

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	☐
Pakistani & British Pakistani	☐	White & Asian	☐
White & Black African	☐	White & Black Caribbean	☐
Ethnic category not stated	☐	Other: ……..……..	☐

First Language …… Other Languages……..

If in full time education, School/college attended

…… **date**……..

Next of Kin

Name ……..
Address……
……..
Home Number ……...
Mobile Number ……..
Relationship to you ……...

Can we contact your Next of Kin in an emergency?	Yes		No	
Can we discuss your medical record with you Next of Kin?	Yes	☐	No	☐
Is your Next of Kin your main carer?	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 ……..

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 …….

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** …….

Health Questionnaire

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 quit? **Y**es □ 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)

All patients over 16, Please complete the attached Alcohol Questionnaire

How tall are you? ……

How much do you weigh? ……

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) ……

Do you take regular medication?

If yes, please list. (If you have a repeat medication order slip, bring it with you to your appointment) Yes No

…… ……

…… ……

Are you allergic to any drugs? Yes No

If so, please list …… ……

…….. ……

Vaccinations

Date of last Tetanus injection …….
Have you had any other travel immunisations? Yes ☐ No ☐
If so, please list……
……

This section should be completed for patients under the age of 16 please.
Has the child had their…..

			Approximate 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)

This section is for completion by female patients 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	☐	

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- I wish to decline a Summary Care Record.**
Do you want a Summary Care Record?	**Yes-** ☐	**No-** ☐

Summary Care Records

NHS

Your emergency care summary

CONFIDENTIAL

OPT-OUT FORM

Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice

A. Please complete in BLOCK CAPITALS

Title ..... Surname / Family name .....

Forename(s) .....

Address .....

Postcode..... Phone No ..... Date of birth .....

NHS Number (if known)..... Signature .....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name ..... Your signature.....

Relationship to patient ..... Date .....

What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please contact your GP practice.

FOR NHS USE ONLY Add Code 9Ndo

Actioned by practice: yes / no Date.....

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.

Patients at Severnbank Surgery can register for online access to allow them the order their prescriptions, book appointments online as well as see their core record. Please tick the boxes below if you wished to be set up for online access when joining Severnbank Surgery.

- ☐ I would like to be set up for online access at Severnbank Surgery
- ☐ I would like to be able to order repeat prescriptions online
- ☐ I would like to be able to book appointments online
- ☐ I would like to be able to see my core record online

All patients are welcomed and encouraged to take part in our Patient Participation Group (PPG). We hold quarterly meetings to give a patient viewpoint on Surgery matters. Would you be interesting in receiving details of the meetings and group activity via the email address you have provided?

☐- I would like to be involved and consent to be emailed using the address provided

☐- I would like to be involved but consent to use a different address: _____

☐- No, I would not like to be involved in the PPG at this time.

Administration Section Only

Allocated/Named GP: …… Patient EMIS Number: ……

New patient screen offered: Y ☐ N ☐ *NPS offered* ☐ *Declined* ☐

Appointment booked: Date…… Time……..

Identity Verified: ……

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)- ☐

I have accepted this patient for general medical services on behalf of the practice ☐

I will dispense medicines/appliances to this patient subject to NHS England approval ☐

Practice Name:

_____

Practice Code:

_____

Practice Stamp: