For office use only.	Photo ID seen	Date
	Proof of address seen	Initials

Sheen Surgery

NEW PATIENT REGISTRATION

Welcome to Sheen Lane Health Centre. You can help us to provide the health care you need by answering the following questions. Please answer as many questions as you can. As a new patient, you will be offered a new patient health check and you can ask about any questions you are unsure of at that time.

PLEASE NOTE THAT YOUR REGISTRATION CANNOT BE COMPLETED UNLESS ALL QUESTIONS MARKED WITH AN * ARE COMPLETED

Surname*	**Forenames***
Date of Birth*	**Marital Status**
Telephone Number	**Occupation**
Mobile Number *	
Email address:*	
Would you like to receive free text messages to remind you about appointments and health info * Y/N	

If a member of your household is already registered with us could you please provide their details as we like to keep households together on our system?

Surname* If more than one person please fill in on separate sheet.		**Forename**	
Date of Birth			
Relationship to you			

Ethnic Origin * – RESPONSE REQUIRED

- ○ British or mixed British ○ Irish ○ Other White background (please state)
- ○ White and Black Caribbean ○ White and Black African
- ○ White and Asian ○ Other mixed background (please state)
- ○ Indian or British Indian ○ Pakistani or British Pakistani
- ○ Bangladeshi or British Bangladeshi ○ Other Asian ethnic group
- ○ Caribbean ○ African ○ Other Black background
- ○ Chinese ○ Other ethnic group (please state)
- ○ Asian & Chinese ○ Arab
- ○ Irish Traveller ○ Gypsy / Romany ○ Traveller
- ○ Ethnic Category Not Stated **(Office use only)**

Height:	**Weight:**

Blood Pressure:* (Please use in house machine): Systolic Diastolic Pulse

Alcohol:	**Please tick one**
Currently drinks	○
Lifelong teetotaller	○
Ex-drinker	○ **Date started** **Date stopped**

How many units of alcohol (if any) do you drink per week? …….. (One glass of wine is approx 2 units, one measure of spirits or half a pint of beer/lager is approx. 1 unit) Approx measurement depending on strength of drink

Smoking*:	**Please tick one**	
Never smoked	○	
Ex Smoker	○	**Date stopped**
Current smoker	○	**How many a day**

Do you consent to receiving SMS notifications from the surgery?* **Y / N**
Do you consent to receiving emails from the surgery?* **Y / N**

Do you have a family history of:

	Y/N	**Mother**	**Father**	**Sister**	**Brother**	**Age of Onset**
Heart Disease						
Stroke						
High Blood Pressure						
Diabetes						

Do you have any medication allergies? YES _____ NO _____

Type of Medication	Type of Reaction

Are you a Carer? YES _____ NO _____
(A carer is anyone who looks after or helps someone who may be ill, disabled, frail or elderly and who without this help would not manage to live independently or in the community).
Do you have a Carer? YES _____ NO _____

If you use any regular medication, please list them. Remember to include creams, inhalers, eye drops and hay fever treatments. If not sure, please bring all bottles and boxes along to your New Patient Health Check.

Name of Drug	**Strength**	**Frequency**
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Do you take Aspirin each day?	YES _____ NO _____
If so, how much?	

Do you have a preferred Pharmacy for your prescriptions? Please tick

Pharmacy	**Tick**
Boots	
Dumlers	
Spatetree	

Superdrug	
Round the Clock	
Other:	

Please list any major operations or important medical problems:

Year	**Problem**
1.	
2.	
3.	
4.	
5.	
6.	

Have you ever had a stroke (CVA) or mini stroke?	YES _____ NO _____
Have you ever had angina or a heart attack?	YES _____ NO _____
If so, have you ever had your cholesterol measured?	YES _____ NO _____

Do you have communication/information needs relating to a disability, impairment or sensory loss?

YES_____NO_____

If you have answered YES please tell us how we can assist you with these needs.

For Women Only

How many pregnancies have you had?	
Are you currently pregnant? If yes, how many weeks?	
When was your last pregnancy?	
When was your last smear test?	
What form of contraception, if any, do you use?	Pill/Coil/Condom/Diaphragm

SHEEN SURGERY **Richmond CCG**

Application Form for Online Access

*Surname	*Date of birth
*First name	
*Address *Postcode	
*Email address	
Landline telephone number	*Mobile number

*Fields marked * are mandatory*

I wish to have access to the following online services (please tick all that apply)

Booking appointments	☐
Requesting repeat prescriptions	☐
Accessing my medical record	☐
I wish to access my medical record online and understand and agree with each statement (tick) 1. I have read and understood the information leaflet provided by the practice (available on request)	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
6. I understand that my medical record is designed to be used by clinical professionals to ensure that I receive the best possible care. Some of the information within my medical record may be highly technical, written by specialists and not easily understood. It may be best not to access my notes for the first time in the evenings or at weekends, when the surgery may be closed.	☐
7. I can confirm that I have not been pressurised by anybody to request access to my medical records.	☐

***Signature of applicant**	***Date**

ALCOHOL QUESTIONNAIRE

Name: DOB:

For the following questions please tick the answer which best applies.

How often do you have a drink that contains alcohol?	**Never** ☐ 0	**Monthly or Less** ☐ 1	**2 - 4 times per month** ☐ 2	**2 - 3 times per week** ☐ 3	**4+ times a week** ☐ 4
How many standard alcoholic drinks do you have on a typical day when you are drinking?	1 - 2 ☐ 0	3 - 4 ☐ 1	5 - 6 ☐ 2	7 - 8 ☐ 3	10 + ☐ 4
How often do you have 6 or more standard drinks on one occasion?	**Never** ☐ 0	**Less than Monthly** ☐ 1	**Monthly** ☐ 2	**Weekly** ☐ 3	**Daily or almost Daily** ☐ 4

Total for Each Column: _____

Total: ____

Scoring: A total of 5+ indicates hazardous or harmful drinking

Register Your Type 1 Opt-out Preference

The data held in your GP medical records is shared with other healthcare professionals for the purposes of your individual care. It is also shared with other organisations to support health and care planning and research.

If you do not want your personally identifiable patient data to be shared outside of your GP practice for purposes except your own care, you can register an opt-out with your GP practice. This is known as a Type 1 Opt-out.

Type 1 Opt-outs may be discontinued in the future. If this happens then they may be turned into a National Data Opt-out. Your GP practice will tell you if this is going to happen and if you need to do anything. More information about the National Data Opt-out is here: https://www.nhs.uk/your-nhs-data-matters/

You can use this form to:

- register a Type 1 Opt-out, for yourself or for a dependent (if you are the parent or legal guardian of the patient) (to **Opt-out**)
- withdraw an existing Type 1 Opt-out, for yourself or a dependent (if you are the parent or legal guardian of the patient) if you have changed your preference (**Opt-in**)

This decision will not affect individual care and you can change your choice at any time, using this form. This form, once completed, should be sent to your GP practice by email or post.

Details of the patient

Title										
Forename(s)										
Surname										
Address										
Phone number										
Date of birth										
NHS Number (if known)										

Details of parent or legal guardian

If you are filling in this form on behalf of a dependent e.g. a child, the GP practice will first check that you have the authority to do so. Please complete the details below:

Name	
Address	
Relationship to patient	

Register your Type 1 Opt-out preference

Your decision

☐ **Opt-out**

I do not allow my identifiable patient data to be shared outside of the GP practice for purposes except my own care.

OR

I do not allow the patient above's identifiable patient data to be shared outside of the GP practice for purposes except their own care.

☐ **Withdraw Opt-out (Opt-in)**

I do allow my identifiable patient data to be shared outside of the GP practice for purposes beyond my own care.

OR

I do allow the patient above's identifiable patient data to be shared outside of the GP practice for purposes beyond their own care.

Your declaration

I confirm that:

- the information I have given in this form is correct
- I am the parent or legal guardian of the dependent person I am making a choice for set out above (if appliable)

Signature _____

Date signed _____

When complete, please post or send by email to your GP practice

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For GP Practice Use Only

Date received		
Date applied		
Tick to select the codes applied	**Opt – Out - Dissent code:** 9Nu0 (827241000000103 |Dissent from secondary use of general practitioner patient identifiable data (finding)|)	
	Opt – In - Dissent withdrawal code: 9Nu1 (827261000000102 |Dissent withdrawn for secondary use of general practitioner patient identifiable data (finding)|)]	