New Patient Registration Form

1. Please complete **one registration form for each member of the family**
2. Please complete in **BLOCK CAPITALS** and tick the boxes as appropriate.
3. Please bring a **form of identification to prove your identity AND address**

Today's Date:	
Usual Branch: (Please select one branch for registration purposes, you can use either branch once registered)	☐ Newmarket Branch, 153 Newmarket, Louth **OR** ☐ The Wolds Branch, West Road, Tetford
Full Name:	
Address:	
Date of Birth:	
Home Telephone Number:	
Mobile Number:	
Marital Status:	
Next of Kin (Name & Relationship): (Please include telephone number if different to above)	
Occupation:	
Ethnic Status: (e.g. White, Mixed, Black, Asian, Chinese etc)	
First Language:	
Religion: (e.g. Christian, Muslim, Jewish, Spiritual etc)	

Dispensing/Non-Dispensing

Dispensing/Non-Dispensing Do you live within 1 mile of a chemist?	**YES / NO** *(If you have selected NO, the Practice will dispense all of your medication to you)*
If you have selected YES, please give them name and address of your selected chemist:	
Would you like us to send your prescription electronically to your selected chemist? (not including controlled drugs)	**YES / NO** *(If you have selected NO, you will need to collect your scripts from the Practice. This is also applicable for all 'Controlled Drugs'. Please speak to the Dispensary if you require further information.)*

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Review due: May 2020

Carers

Are you a Carer? (Do you look after someone who is chronically ill, frail, disabled or mentally ill)	YES / NO
Are you yourself being cared for long-term?	**YES / NO**

The Practice is keen to identify Carers and those cared for so that we can help you access the most up-to-date information, advice and support available.

Health

What is your height and weight?	Height:	Weight:
Major Illnesses, Accidents, Operations		
Are you on repeat medication?	**YES / NO** (If YES, please bring with you your repeats slip from your last medication collection as early as possible)	
Do you have any drug or other allergies?		

Do you smoke?	YES / NO / EX-SMOKER
If 'YES', how many per day?	**……………… Cigarettes ………….. Pipes/Cigars**

All smoking endangers your health and the health of those around you. If you are a smoker and want to stop, please ask for information at your New Patient Health Check.

How much alcohol do you drink in a week? (To be answered by patients aged 16 and over)	……………………….Unit(s) *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)*
How often do you exercise?	**Heavy Exercise** **Moderate Exercise** (regular exercise for more the ½ hour, 3+ times a week) **Light Exercise** (regular exercise for at least ½ hour, 1-2 times a week) **Exercise Impossible**

Are you aware of any family history? Please state which relative. (E.g. Heart Attack, Stroke, Breast Cancer, Diabetes etc)	

Special Needs

Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:

Please state any Special Needs you may have This may include the following: Speech, Hearing, Sight impairment, Physical disabilities, Mental disabilities, Phobias etc	
Are you an 'Assistance Dog' User?	**YES / NO**
Please state any Religious or Cultural needs:	
Do you require the help of a Translator / Interpreter?	**YES / NO**

Your health record and sharing of Information

Please read this leaflet carefully. It provides information about the choices you can make about sharing your health record. Your health record includes your medical history, details about your medication and any allergies you may have. You can now choose whether to share these full medical details. We use a secure electronic health records system called SystmOne.

With your permission, this system can allow clinicians to share your full record held here with other healthcare services who are providing care for you. These other services will ask your permission to view your record.

Many organisations use SystmOne including some GP practices, out of hours services, children's services, community services and some hospitals. Sharing your health record will help us deliver the best level of care for you. You have **two choices** which allow you to control how your record is shared. You can change these choices at any time by letting the relevant practice or service know.

Please read this leaflet and fill in your choices. You may wish to keep this section for future information.

Your choices at **each practice** or **service:**

Sharing OUT - This controls whether your information recorded at this practice or service can be shared with other healthcare services.

Sharing IN - This determines whether or not this practice or service can view information in your record that has been entered by other services who are providing care for you, or who may provide care for you in the future.

Imagine you're receiving care from three services: your GP, a district nurse and a smoking clinic. You want your GP and District Nurse to share information with each other and you want both of them to know your progress at the smoking clinic. However, you don't want the smoking clinic to see any of your other medical information.

Your sharing choices at each practice or service would be: • The GP can share information IN and OUT. • The district nurse can share IN and OUT. • The smoking clinic can only share information OUT but not IN.	

You can change your choices at any time. Let the practice or service know.

Please complete your details below and make your choices. Please complete a separate form for each of your dependents. Complete this section and return to the practice or receptionist. If we do not receive this section completed, we will get in contact to ask you to confirm your preferences.

The choices you would like to make about sharing your health record:

SHARING OUT I would like my health record at this practice or service to be shared with other healthcare services providing care for me.	**YES / NO**
SHARING IN I would like this practice or service to be able to view information in my health record that has been recorded by other healthcare services.	**YES / NO**

PATIENT NAME: ……………………………………………………………… **DATE OF BIRTH :**…………………………………….

SIGNATURE: ………………………………………………………………………… **DATE:**……………………………………………

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East Lindsey Medical Group

Patient Consent for Email and Text Message Communication

The practice wishes to expand its methods of communicating with patients to include the use of email and text messaging.

Patient Privacy is important to us, and East Lindsey Medical Group would like to communicate with you regarding any activities that may be of interest, which means that we need your consent.

This may include using emails to provide updates on new developments at the practice, and the use of text messaging to send patients reminders about the details of their next appointment.

Emails and text messages are generated using a secure facility, but because they are transmitted over a public network they may not be secure. Email and text communication will never be used for urgent communications. Your contact details will be used solely in relation to healthcare services offered by the practice, and you can choose to opt out of the services at any time by contacting East Lindsey Medical Group.

Please complete this form and hand it in at the practice reception
if you consent to any, or all, of the above.

Patient Name	
Date of Birth	
Mobile	**Email**
Mobile Number:	**Email Address:**
Consent to use? Please state Yes or No	**Consent to use?** Please state Yes or No
I agree to advise the practice if my mobile number and/or email address changes, or if this is no longer in my possession.	
Signature	
Date:	

Please confirm your consent to one (or more) of the following;

☐ **Newsletters and Information on Practice Services**

☐ **Appointment confirmation and reminders**

☐ **Requests to contact the surgery (non-urgent)**

You can grant consent to all the purposes of use, one of them or none of them. Where a patient does not grant consent then the Practice will not be able to use their personal data.