Ainsdale Medical Centre

AINSDALE MEDICAL CENTRE
New Patient Information Form

Today's Date:

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Please complete a separate form for each family member to be registered.

Full Name:					**Telephone Number:**
Mr / Mrs / Miss / Ms / Other……..					**Work Number**
Address and Postcode					**Mobile Number:** Do not use this number to send SMS messages ☐
					Next of Kin: **Can we contact them in an emergency? Yes/No** **Next of Kin Contact Number:** **Next of Kin Relationship to you:**
Date of Birth:		**Previous / Mother's surname if different:**			
Age:		**Town & Country of Birth**			
Marital Status:		**Gender:**	**Male:**	**Female:**	**Other residents of your home:**
Occupation:					
Names & Ages of Children					**NHS Number (If known)**

On-Line Services: We encourage our patients to use our on-line services to order any repeat medications they take and to book appointments.

Enclosed with your registration pack is an application form to enrol for Patient Access. Please complete the form and bring it to the surgery with two forms of current identification – one must carry a photograph and one your address.

If you would like to nominate a pharmacy for us to send your prescriptions to via the Electronic Prescription Service (EPS) please indicate the name below (note that you can change this or revert back to paper at any time),

Name of pharmacy:

If returning from Armed Forces:	**Your Service or Personnel Number**	**Your Enlistment Date**

Your Religion tick which applies:	**C of E**	**Catholic**	**Jewish**	**Other Christian (state)**	**Buddhist**	**Hindu**	**Muslim**
	Sikh	**Jehovah's Witness**		**Other religion (state)**	**No religion**	**Do not wish to disclose**	

Your Ethnic Origin: (select one)	White (UK) 9i0	White (Irish) 9i1%	White (Other) 9i2%
Caribbean 9i3	African 9i4	Asian 9i5	Other Mixed Background 9i6%
Indian / Brit Indian 9i7	Pakistani / Brit Pakistani 9i8	Bangladeshi / Brit Bangladeshi 9i9	Other Asian Background 9iA%
Other Black Background	Chinese 9iE	Other 9iF%	Ethnic Category not stated 9iG

Is English your main or first language?	Yes	No	If no then what is your first language?

Smoking, Alcohol Consumption and Exercise:

Have you ever been a smoker?	Yes	No	Are you currently a smoker?	Yes	No

If so, how many cigarettes / cigars / tobacco do you smoke in a typical day?		How much alcohol do you drink in a week (Units)? *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)*	
If you are a smoker and want to stop, please ask for information about local smoking cessation services.			

How often do you exercise?	No. times per week	Type(s) of exercise:	

Your Medical Background:

What illnesses have you had & when?		
What operations have you had and when?		
Do you have any medical problems at present?		
Please list any tablets, medicines, or other treatments you are currently taking: (incl. dose + frequency)		
Are you able to administer your own medicines?	Yes	**No** *(Please detail specific issues e.g. swallowing, opening containers)*

Are there any serious diseases that affect your Parents, Brothers or Sisters (Tick all that apply)	**Diabetes**	**Heart Attack**	**Heart attack underage of 60**	**Bowel Cancer**	
	Breast Cancer		**High Blood Pressure**	**Asthma**	**Stroke**
	Thyroid Disorder		**Any other important Family Illness?**		

What immunisations have you had? (Please tick all that apply)	**Diphtheria**	**Measles**	**German Measles**	**Tetanus**	**Polio**	**MMR**
	Whooping Cough		**Pre-school booster**	**Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses**		

Specific 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 Sensory Impairment you have (i.e. Speech, Hearing, Sight):	
Are you an 'Assistance Dog User?	
Please state any Physical disabilities you have:	
Please state any Mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises.	
Please state any Religious or Cultural needs:	
Do you require the help of a Translator / Interpreter?	
Please state any specific nutritional requirements you have:	
Please state any allergies and sensitivities you have:	
Please state any phobias you have:	
If you are a Carer, please state the name/address / phone number of the person you care for:	**Person Cared for Contact Details:** Is this person a patient of our practice? Yes / No
If you have a Carer, please state their name/address / phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer Contact Details:** Is this person a patient of our practice? Yes / No **I consent for you to disclose my health details to the above-named person:** **Signed:** **Date:**

Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	**Yes / No**	***If "Yes", can you please bring a written copy of it to your New Patient Consultation***
Have you nominated someone to speak on your behalf (e.g., someone with Power of Attorney)?	**Yes / No**	**If "Yes", please state their name/address / phone number: Please also provide a copy of the document for us to keep with your record.**

Complete as applicable:

When was your last smear done?	**Date**	**Was this at your GP's Surgery?**	**Yes**	**NO**
What was the result of the smear?				
Date of the last mammogram (if applicable):	**Date**	**Method of contraception (if used):**		
Do you wish to see a doctor for contraceptive services (including the pill, coil or cap) in this practice?			**Yes**	**NO**

Data Sharing

Sharing of medical records with other parties is becoming more commonplace in healthcare. Many data-sharing programmes are designed to help other health professionals look after you better by letting them see parts of your medical records. Other sharing schemes are designed to help better analysis of healthcare needs to make sure that appropriate services are provided to the population.

Please read the leaflet about data sharing we have given you and complete the form accordingly. Unless you indicate otherwise by completing the preferences form you will be automatically INCLUDED in any sharing programmes in which Ainsdale Medical Centre participate.

Ainsdale Medical Centre is registered under the Data Protection Act

Patient Engagement

The Practice is committed to improving the services we provide to our patients.
To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better. We operate the NHS Friends and Family Test, a patient satisfaction survey that runs in hospitals. You can complete a survey form in the surgery.
We also run a Patient Reference Group (PPG), a small group of patients who meet about four times a year and hold online discussions in a web forum. If you would like to join our PPG, please contact the Deputy Practice Manager, who will be able to provide more information.

Patient Signature:	**Name:** **Signature:**	**Signature on behalf of patient:**	

Thank you for completing this form

For more information about the services we offer, see our website: www.ainsdalemedicalcentre.nhs.uk