Courtyard Surgery
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Tel: 01403 330320
www.courtyardsurgery.com

NEW PATIENT ADULT REGISTRATION FORM (16+)

TITLE & SURNAME: FIRST NAME:

Former Name: Date of Birth:

Gender: NHS No (if known):

House Name/Number: Marital Status:

Road: Occupation:

Town:

Postcode:

Home Phone: Mobile Phone:

E-mail address:

Ethnicity – please indicate your ethnicity

☐ White British
☐ White Irish
☐ Other White background
☐ White & Black Caribbean
☐ White & Black African
☐ White Asian
☐ Other Mixed background
☐ Indian / British Indian
☐ Pakistani / British Pakistani
☐ Bangladeshi / British Bangladeshi
☐ Other Asian background
☐ Black Caribbean
☐ Black African
☐ Other Black background
☐ Chinese
☐ Other Ethnic Group
☐ Not stated
☐ Do not wish to give ethnicity

☐ I give consent to receive messages by text (this will include appointment reminders, messages and general information about the surgery)

☐ I give consent to receive messages by e-mail (this will include messages and general information about the surgery)

I give consent for voicemail messages to be left on my (please indicate): ☐ home phone ☐ mobile telephone

Carers
Do you look after someone? ☐ Yes ☐ No – if yes, please ask our receptionist for a Carer's registration form
Does someone look after you? ☐ Yes ☐ No

Military Veteran
Are you a military veteran? ☐ Yes ☐ No

Health Questions
When you first register, we may not have access to your full past medical history. It would therefore be helpful if you would complete the following section.
Past Medical History – please list any serious illnesses, operations, accidents, or disabilities.

Year:	**Problem:**

What is your height? **What is your weight?**

Medication: please give details of any treatments or drugs that you currently use. It would be best to provide us with a copy of your current repeat prescription where possible.

Drug Name & Strength	Frequency of Use	Condition Treated by drug:

Drug Allergies – If you have any allergies or have had any adverse reactions to drugs please let us know.

Drug Name:	Problem Caused:

Other Allergies:

Pharmacy Nomination.
We can arrange for your prescriptions to be sent directly to your chosen Pharmacy.

Name of Pharmacy: **Location:**

SMOKING (please circle one) **Never Smoked / Ex-Smoker / Current Smoker**

ALCOHOL USAGE QUESTIONNAIRE

UNITS	 **2**	 **1.5**	 **2**	 **1**	 **9**
	Pint of regular Beer/Lager/ Cider	Alcopop or Can of Lager	Glass of Wine (175ml)	Single Measure of Spirits	Bottle of Wine

How many units of alcohol do you consume in a week?

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

EXERCISE
Please tick the description that best describes your exercise routine:

☐ **ACTIVE** Exercise for 30 minutes, 5 times per week
☐ **MODERATE** Exercise for 30 minutes, 2-3 times per week
☐ **INACTIVE** No exercise at all
☐ **UNABLE TO EXERCISE**

OTHER FACTORS AND FAMILY HISTORY

Other Factors **Please tick any of the following conditions that you suffer from:** ☐ Asthma ☐ Diabetes ☐ Epilepsy ☐ Angina ☐ Heart Attack ☐ Stroke	**Family History** *Please list any illnesses that run in your family:* Mother's side: Father's side: Brothers and Sisters: Other:

Has any member of your immediate family (i.e. mother, father, brothers & sisters) had a heart attack or stroke under the age of 60? If yes, please give details

☐ Yes ☐ No

COMMUNICATION NEEDS

Do you have any communication requirements? If yes, please give details. ☐ Yes ☐ No

☐ Large print ☐ Translation Service ☐ Sign language

☐ Any other (please give details):

How would you like us to communicate and send information to you?

What is your first language?

SHARING AND YOUR CONSENT

We would like to obtain your permission and consent to sharing your medical record with NHS England and other healthcare professionals. Please tick your preferences to all items.

Summary Care Record (SCR) – Your Summary Care Record is a short summary of your GP medical records. It tells other health care staff that care for you about the medicines you take and your allergies.
This can help in an emergency, when you're on holiday, out-patient clinics, a pharmacy and when your surgery is closed**.**

☐ I would like to **opt out** of the Summary Care Records Programme and have completed the appropriate form **(please obtain from reception)**
For more information on SCR visit https://digital.nhs.uk/summary-care-records/patients

Consent to Share your Medical Information

At Courtyard Surgery, we use **TPP SystmOne** as our clinical system. Some organisations, including local services such as the Minor Injuries Unit at Horsham Hospital and the District Nursing Team use the same system. With your permission, your GP would be able to see any information recorded by these services as well as those services being able to see your GP record. When you attend a new place of care, your consent will always be sought to enable this sharing.

☐ I am happy to share my data in & out (your GP record will be visible to other organisations that care for you, with your consent, and entries made by other healthcare organisations can be viewed by your GP.

☐ I do not wish to share my data as above

EMERGENCY CONTACTS
We would be grateful if you could give us the details of a person(s) that can be contacted in an emergency – this information will be added to your medical record. Please note that we will not discuss any information without your consent.

Name		
Contact details		
Relationship to me		

ON-LINE SERVICES
You are able to book routine GP appointments, as well as order your repeat prescription with this service.

You should keep your login details in a secure and safe place.

Due to the complexities of the Nursing teams clinics it will not be possible to book nurse appointments using the online service.

Please indicate below if you would like to sign up for this service
☐ Yes - I would like to register for Courtyard Surgery On-Line services

I would like to receive my log-in details for online services via (please tick): ☐ SMS ☐ Post

☐ I will adhere to Courtyard Surgery's Guidance Policy for the use of online services **(available at reception).** It is my responsibility to keep my account secure by keeping my log-in details confidential. I understand that I can terminate my account at any time by contacting the surgery.

PATIENT PARTICIPATION GROUP (PPG)
Please let us know if you would be interested in being a member of the Courtyard PPG and be involved in decisions about the services provided by the surgery, and the Practice Manger will contact you.

YES/NO

PATIENT DISCLAIMER
Thank you for choosing to register at Courtyard Surgery. Your registration will be completed shortly on our clinical system. For further information about the surgery visit our website www.courtyardsurgery.com where you can also see the latest news.

☐ I understand that it is my responsibility to update Courtyard Surgery if any of my details, such as contact numbers or address, change.

Signed: Date:

Print Name:

SURGERY ADMINISTRATION
Registration form taken in by: Date
Forms of ID seen:
Date registration added to SystmOne: Registered by:

Check if patient is a carer - if yes, please task Care Co-Ordinator to update register and make contact
PPG – if yes, please task Management to make contact
Check if patient is a military veteran – if yes, please task Daisy to add information to records
☐ Emergency Contacts / Family members added to Groups & Relationships