15+

THE CHISLEHURST MEDICAL PRACTICE

Patient Registration Form – please PRINT use black ink
All information supplied is treated confidentially and forms a part of your medical record.

Name:……

Tel No Home:…… **Mobile:**……**.** Patients aged 13 years and over must have an individual mobile number.

Email address (must be different for each individual)…….

Nominated Pharmacy for your medication ……..
(This is sent electronically)
Please attach a copy of your latest list of medication to your application

Occupation:……..

School currently attended……..

Next of Kin Name:…….
ContactNo……
Relationship to you……..

Are you are carer? If so please give details ……..

Does someone care for you? If so please give details ……

What is your ethnic group? Please tick the appropriate box

White	British		Irish		Any Other White background			
Mixed	White & Black Caribbean		White & Black African		White & Asian		Any Other Mixed background	
Asian or Asian British	Indian		Pakistani		Bangladeshi		Any Other Asian Background	
Black or Black British	Caribbean		African		Any Other Black Background			
Other	Chinese							

If your first language is NOT English please complete

First language Spoken……Interpreter Required Yes/No

CONSENT OPTIONS

All patients registered at this surgery will automatically have a summary care record created unless they have expressed a specific preference to opt out. To learn more visit www.nhs.uk/your-nhs-data-matters or call 0300 303 5678
The Practice also has access to the Local Care Record.
More information can be found on the website www.chislehurstmedicalpractice.co.uk

If you require further information regarding consent please visit the Practice Website www.chislehurstmedicalpractice.co.uk

ONLINE ACCESS

Please download the NHS app and create an account in order to access appointment booking and request your repeat medications.
If you require access for anyone under 13 or full access to your record please complete the form at the end of this document for proxy access

The surgery sends text reminders, recalls and urgent messages via text. It is your responsibility to notify us of any changes to your mobile number in writing.
If you wish to receive reminder you MUST consent here
☐ **I consent to receiving SMS text messages from the surgery**

☐ **I do not wish to receive SMS text messages from the surgery**

Getting in touch is sometimes difficult. Currently we do not leave voice messages without patient consent. Please indicate if you would like us to leave you a brief message.
☐ **I consent for messages to be left on my mobile voicemail and understand my responsibility as set out below:-**
It is essential that you ensure that we have the most up to date mobile number for you. Updates to this information can be done when booking an appointment or in writing.

In the future we may to wish to communicate with you via email. Please indicate if this would be a useful option for you and you would like to use this facility.
☐ **I consent to receiving communication via email and understand my responsibility as set out below:-**
It is essential that you understand that you are responsible for ensuring that we have the correct email address and who has access to this information
– updates only accepted in writing via change of details form –

MEDICAL QUESTIONNAIRE

All new patients can book a new patient health check. Please ask at Reception

Height: …….. Weight: ……..

Smoking Status (please tick) Never Smoked……
Current smoker ……per day Ex-smokergave up……(month/year)

Are you allergic to anything? Yes /No Details: …….

Date of MMR vaccination……Date of booster MMR……..

Do you know your HIV status? YES NO
If no we can offer a confidential HIV test, please ask at reception

We offer Hepatitis A & B vaccination if you are from an at risk area

Have any of your immediate relatives suffered from any of the following:-

Please tick as appropriate	Relative e.g. mother, sister	Under 60	Over 60
Angina or Heart Attack			
Stroke			
High Cholesterol			
Asthma			
Diabetes			
Cancer (please specify)			
High Blood Pressure			

Please add any other information that you would like the doctors to know about you. Please include any special requirements such as disability access

……

Alcohol: (Patients 15 yrs and over)

In moderation alcohol can be part of a healthy lifestyle, but excessive alcohol can be harmful to you. We would be grateful if you could answer the following questions as honestly and accurately as possible. To help answer the questions use the alcohol unit guide below to help estimate the amount of alcohol you drink.

No of units of alcohol per week……..

15+

	Questions	Scoring system					Score
		0	1	2	3	4	
1.	How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
2.	How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 8	10+	
3.	How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
						TOTAL	

Please score your questions. For example if the answer to question 1 is 'monthly or less' this will score 1 for that question Add your scores for questions 1-3.
A total score of 4 or less for the above 3 questions is an indicator of a safe level of drinking. If you total score is 5 or more then please continue with questions 4-10 on the next page:

	Questions	Scoring system					Score
		0	1	2	3	4	
4.	How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5.	How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6.	How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7.	How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8.	How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9.	Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10.	Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
If you have completed questions 4-10 this may indicate that there is a potential health implication due to drinking alcohol. We invite you to make a routine appointment to discuss this further. **TOTAL**							

15+

ONLINE SERVICES REGISTRATION FORM

MAKE APPOINTMENTS, REQUEST REPEAT PRESCRIPTIONS & VIEW YOUR MEDICAL RECORD ONLINE

Once you are registered for the Patient Access System you are able to; - make appointments, request prescriptions and view your GP medical record online. The Patient Access medical record viewer allows you to look at test results, details of consultations and your medical history, including current and past medication.

If you would like to have secure online access to your records, we need to make sure that you understand what this involves and that you are happy for us to use the information provided below to set up and operate the service. **You will need to provide one form of photographic ID e.g. Passport or driving licence**

The following form will take you through the things you need to think about. By signing this form you accept the declarations listed below and will be giving us your permission to go ahead with setting up the service for you (subject to your specific access requests). If you decide not to join, or wish to withdraw, it will not affect your treatment in any way.

The practice makes every effort to record information as accurately as possible, however there may be information that you do not feel is correct.

Conditions of Use and Declaration (please read the following and sign to accept):

1. I have read and understood this information leaflet about this service and access to GP medical records.
2. I agree to use the system in a responsible manner in accordance with all instructions given to me by the practice. If not, access may be withdrawn.

3. If I see information which does not relate to me, I will immediately log out and report the matter to the practice as soon as possible.

4. I agree that it is my responsibility to keep my username and passwords secure. If I think these have been shared inappropriately I will reset them using the instructions supplied. I am also responsible for keeping safe any information I may print from the record.

5. I agree that my details below may be used to contact me about how useful I find the service and whether it could be improved.

6. If I notice any inaccuracies with my record, I will inform the Practice Manager as soon as possible of any errors or omissions.

7. I understand that I may see information on my record that I was unaware of / have forgotten about that could cause distress.

8. I understand that, as before I will be informed directly by the practice, of any test results which require further action. However I understand that I may see these results online before the practice has been able to contact me. This could be while the surgery is closed and there is no one available to discuss them with me.

KEEP THIS PAGE FOR REFERENCE

 APPLICANTS REQUIRING ONLINE ACCESS TO FULL MEDICAL RECORD

PATIENT DETAILS	
FULL NAME	
DATE OF BIRTH	
FULL ADDRESS	
MOBILE NUMBER	
EMAIL ADDRESS	

If you are requesting on behalf of a child under 13 or for a patient for whom you have legal responsibility, please give your details below

PARENTS/ GUARDIANS & CARERS	
FULL NAME	
DATE OF BIRTH	
FULL ADDRESS	
MOBILE NUMBER	
EMAIL ADDRESS	
RELATIONSHIP TO PATIENT	

PLEASE TICK AS APPLICABLE	
I have not yet registered and wish to request access to view my medical record	
I have read and accept the conditions of use	
PLEASE TICK ONE OPTION BELOW	
I am the patient detailed above	
I am the legal parent/ guardian of the child named above and the child is under 13	
I have legal responsibility and consent to access the record of patient named above	

Signed		**Date**	

OFFICE USE ONLY - PHOTO ID SEEN							
PASSPORT		**DRIVING LICENCE**		**FREEDOM PASS**		**OTHER**	
DATE				**CHECKED BY**			