ASCOT MEDICAL CENTRE
Ascot Medical Centre
Heatherwood Hospital
Brook House, Brook Avenue
Ascot, Berkshire
SL5 7GB
Telephone: 01344 874011
https://ascotmedicalcentre.nhs.uk/

New Patient Registration Form

August 2021

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.

Please bring your passport and/or ID Card to confirm your date of birth & address.

For first time NHS registrations, please provide adequate proof of ID & address & entitlement to NHS treatment.

Proof of ID Seen	Yes / No
Checked Date of Birth	Yes / No DOB:
Checked NHS Number	Yes / No NHS No:
Form of ID Seen	Driving Licence ☐ Passport ☐ Disabled Driver Card ☐ EU ID Card ☐ OAP Travel Card ☐

Staff Print _____

_____

Full Name:					**Telephone Number:**
Mr / Mrs / Miss / Ms / Other……..					**Work Number**
Address and Postcode					**Mobile Number:**
					E-mail Address:
					Next of Kin:
					Next of Kin Contact Number:
Date of Birth:		**Previous / Mother's surname if different:**			**Town & Country of Birth**
Marital Status:		**Gender:**	**Male:**	**Female:**	**Other residents of your home:**
Occupation:					

Names & Ages of Children							
Housing (Select one)	**House**	**Maisonette**	**Flat**	**Mobile Home**	**NHS Number (If Known)**		
Previous Address					**Previous Postcode:**		
					Previous Doctor Telephone No.		
Previous Doctor Name & Address:					**Previous data released?**	**Yes**	**No**
					If applicable, date you first came to live in Britain:		
If returning from Armed Forces:	**Your Service or Personnel Number**				**Your Enlistment Date**		
Your height:	**Feet / inches**	**cm**	**Your weight:**		**Stones / lbs**	**KG**	

Your Religion	**C of E**	**Catholic**	**Other Christian (state)**	**Buddhist**	**Hindu**	**Muslim**
	Sikh	**Jewish**	**Jehovah's Witness**	**No religion**	**Other religion (state)**	

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**

Your main or 1st language Spoken / Understood: (select one)		**English**	**Hindi**	**Gujurati**	**Urdu**	**Bengali /Sytheti**	**Punjabi**
Polish	**Ukrainian**	**French**	**German**	**Spanish**	**Other: (Please Specify)**		

Smoking, Alcohol Consumption and Exercise:					
Are you currently a smoker?	**Yes**	**No**	**Have you ever been a smoker?**	**Yes**	**No**
If so, how many cigarettes / cigars / tobacco do you smoke in a week?			**If you have stopped smoking, when did you stop?**		**Date:**
How long had you smoked for?			**_____ months** **_____ years**		

How often do you have a drink containing alcohol? **1 drink = ½ pint of beer OR 1 x 125ml glass wine OR 1 x single spirit** **1 unit of alcohol=10cc of alcohol** **= Small glass wine (125ml) of 12% wine is 12.5 * 0.12 = 1.5 units** **Recommended weekly limit of units of alcohol for :-** **WOMEN = 21 UNITS** **MEN = 28 UNITS**	**Never** **Monthly or less** **_____** **2-4 times /** **_____** **Month** **2-3 times/** **_____** **week** **4 or more** **_____** **Times/week**	**How many standard drinks containing alcohol do you have on a typical day?**	**None _____** **1 or 2 _____** **3 or 4 _____** **5 or 6 _____** **7 or 8 _____** **9 or more _____**
MEN ONLY: How often do you have EIGHT or more drinks on one occasion?	**Never _____** **< Monthly _____** **Monthly _____** **Weekly _____** **Daily _____**	**WOMEN ONLY: How often do you have SIX or more drinks on one occasion?**	**Never _____** **< than Monthly _____** **Monthly _____** **Weekly _____** **Daily _____**
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 including over the counter and herbal (incl. dose + frequency)	

Are there any serious diseases that	**Diabetes** **TYPE 1 / TYPE 2**	**Chronic Heart Disease**	**Bowel Cancer**

affect your Parents, Siblings & state who (tick/circle all that apply)	**Breast Cancer**		**High Blood Pressure**	**Asthma**	**Stroke**
	Thyroid Disorder		**Any other important Family Illness?**		

What immunisations/ vaccinations have you had & date? (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:**	
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:** **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. a person who has Power of Attorney)?	**Yes / No**	**If "Yes", please state their name / address / phone number:**

WOMEN ONLY			
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 last mammogram (if applicable):	**Date**	**Method of contraception (if used):**	

Summary Care Records

The NHS is changing the way your health information is stored and managed. The NHS Summary Care Record is an electronic record of important information about your health. It will be available to health care staff providing your NHS Care. Please see the information regarding Share your Care and Summary Care Records available in the Waiting Room. If you do not wish to have any of your information viewed by an NHS Medical Professional, please answer NO below and ask Reception for an OPT OUT FORM which needs to be signed and dated.
IF YOU ARE UNSURE WHAT THIS MEANS, PLEASE ASK AT RECEPTION FOR AN EXPLANATION

Are you happy to have a Summary Care Record?	**Yes**	**No**	**More Time Required to decide:**

Patient Participation Group

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.
By expressing your interest, you will be helping us to plan ways of involving patients that suit you.
It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.
If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.

Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the "Yes" Box)	**Yes**

Patient Signature:		**Signature on behalf of Patient:**	

If you are currently on any medication prescribed from your previous GP Surgery, please make an appointment with Reception to see a GP in the next 2 weeks.

If you are aged between 40 and 74 years old, we can offer you a free NHS Healthcheck with our Healthcare Assistant which have designated times on a Monday afternoon. Please arrange for this when you register as you can book up to 4 weeks in advance.

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or visit our website:
www.rhsamc.co.uk

GDPR law from May 2018

The GDPR and Data Protection Act 2018 replaced the Data Protection Act 1998 with an updated and strengthened data protection framework, however, the key principles of the original Act remain unchanged. GP Practices are Data Controllers for the data they hold about their patients. Although almost all Practices will have data that is processed on their behalf by third parties, for example their IT suppliers, it is the Practice as Data Controller that has the responsibility for compliance under the Regulation – further information can be found https://www.bma.org.uk/advice/employment/ethics/confidentiality-and-health-records/gps-as-data-controllers

Yes, I give consent for the Practice to contact me for health related matters either by SMS text, email, letter or by telephone (either mobile or landline)	**Yes**

Patient Signature:		**Signature on behalf of Patient:**	

ASCOT MEDICAL CENTRE

EMIS Patient Access Application Form

EMIS Patient Access allows you to use on-line services to book appointments, order repeat medication and view your medical records. Please note that the medical records view is only available to patients aged 16 years and over.

To register to use Patient Access, all patients will need to complete this form and hand it to a member of the surgery Reception staff, together with any of the following photographic ID.

- *Photo Driving Licence*
- *Passport (& Visa if necessary)*
- *Disabled Drivers Pass*
- *Student ID Card*
- *Travel Card*
- *European ID Card*

To verify identification, completed forms **MUST** be presented to Reception staff **in person by the person requesting access.**

Once Reception staff have been able to verify your identity, they will issue you with your registration letter.

Patient to complete

Name:	
D.O.B:	
Address:	
Home Tel No:	
Mobile No:	
E-mail Address:	

I Am the Patient ☐

Patient Signature_____ Date_____

For Completion by Surgery Staff Only

Proof of ID Seen	Yes/ No
Form of ID Seen	Driving Licence ☐ Passport ☐ Disabled Driver Card ☐ European ID Card ☐ OAP Travel Card ☐
Access Letter Printed	Yes/ No Date
Access Registration Code	Yes/ No Date

Staff Signature _____

Staff Print _____