



ASCOT MEDICAL CENTRE

Brook House
Brook Avenue
Ascot
SL5 7GB

Tel: 01344 874 011

www.ascotmedicalcentre.nhs.uk

November 2022

New Patient Registration Form

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.

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 <input type="checkbox"/> Passport <input type="checkbox"/> Disabled Driver Card <input type="checkbox"/> EU ID Card <input type="checkbox"/> OAP Travel Card <input type="checkbox"/>

Staff Print _____

Full Name:		Home Telephone Number:			
Mr / Mrs / Miss / Ms / Other.....		Mobile Number :			
Address and Postcode :		Work Number :			
		E-mail address :			
		Next of Kin :			
		Next of Kin Relationship to you :			
Next of Kin Contact Number :		Town & Country of Birth :			
Date of Birth:	Previous / Mother's surname if different:				
Marital Status:	Gender:	Male:	Female:	Other:	Other residents of your home:
Occupation:					
Names & Ages of Children (if applicable)					

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		

<p>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</p> <p>1 unit of alcohol=10cc of alcohol = Small glass wine (125ml) of 12% wine is 12.5 * 0.12 = 1.5 units</p> <p>Recommended weekly limit of units of alcohol for :- WOMEN = 21 UNITS MEN = 28 UNITS</p>	<p>Never _____</p> <p>Monthly or less _____</p> <p>2-4 times / _____ Month</p> <p>2-3 times/ _____ week</p> <p>4 or more _____</p> <p>_____ Times/week</p>	<p>How many standard drinks containing alcohol do you have on a typical day?</p>	<p>None _____</p> <p>1 or 2 _____</p> <p>3 or 4 _____</p> <p>5 or 6 _____</p> <p>7 or 8 _____</p> <p>9 or more _____</p>
<p>MEN ONLY: How often do you have EIGHT or more drinks on one occasion?</p>	<p>Never _____</p> <p>< Monthly _____</p> <p>Monthly _____</p> <p>Weekly _____</p> <p>Daily _____</p>	<p>WOMEN ONLY: How often do you have SIX or more drinks on one occasion?</p>	<p>Never _____</p> <p>< than Monthly _____</p> <p>Monthly _____</p> <p>Weekly _____</p> <p>Daily _____</p>
<p>How often do you exercise?</p>	<p>No. times per week</p>	<p>Type(s) of exercise:</p>	

Your Medical Background:	
<p>What illnesses have you had & When?</p>	
<p>What operations have you had and When?</p>	
<p>Do you have any medical problems at present?</p>	
<p>Please list any tablets, medicines or other treatments you are currently taking including over the counter and herbal (incl. dose + frequency)</p>	
<p>What is your preferred pharmacy nomination?</p>	

Are there any serious diseases that affect your Parents, Siblings & state who (tick/circle all that apply)	Diabetes TYPE 1 / TYPE 2		Chronic Heart Disease		Bowel Cancer		
	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:			<u>Person Cared For Contact Details:</u>				
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.			<u>Carer Contact Details:</u>				
			<u>Signed:</u>		<u>Date:</u>		
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:
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WOMEN ONLY

When was your last smear done?	Date	Was this at your GP's Surgery?	Yes / No
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What was the result of the smear?			
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Date of last mammogram (if applicable):	Date	Method of contraception (if used):	
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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:
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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
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Patient Signature:		Signature on behalf of Patient:	
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If you are currently on any medication prescribed from your previous GP Surgery, please make an appointment with Reception to see our local Pharmacy team which is usually via telephone consultation.

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 or Wednesday.

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.ascotmedicalcentre@nhs.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:**