This form is to register as an NHS patient with Sunbury Health Centre Group Practice. Please complete the details below in CAPITALS and delete as appropriate at the *. Once completed **please bring to the practice reception with photo ID and proof of address.**

*Mr / Mrs / Miss / Ms **Surname** _____

Date of Birth | D | D | M | M | Y | Y | Y | Y | **First Name(s)** _____

NHS No _____ Previous Surname(s) _____

***Male / Female** _____ Town & Country of Birth _____

Home Address _____

_____ **Postcode** _____Is this a residential Home? **Yes / No**

Phone Number: Home _____ **Work** _____ **Mobile** _____

Email Address _____

Ethnic Group (*please circle*)

White UK **W**hite European (*please specify*)_____ **I**rish **B**lack **C**aribbean **B**lack African

Black Other **I**ndian **P**akistani **B**angladeshi **C**hinese **O**ther Ethnic (*please specify*)_____

First language: English - **Yes / No** If **No**, please specify _____

Please help us trace your previous medical records by providing the following information

Have you been registered with this practice before? **Yes / No** *(please circle)*

Your previous address in UK _____

_____ Postcode _____

Name of previous doctor while at this address _____

Address of previous doctor _____ Postcode _____

If you are from abroad

Your first UK address when registered with a GP _____

If previously resident in UK, date of leaving _____ Date you first came to live in the UK _____

If you are returning from the Armed Forces

Address before enlisting _____

Service or personnel number _____ Enlistment date | D | D | M | M | Y | Y | Y | Y |

If you are registering a child under 5, please tick if appropriate

☐ I wish the child above to be registered for Child Health Immunisations

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PLEASE SIGN BELOW as *signature of patient or *on behalf of patient

..... Date _____

NHS Organ Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. **Please circle** as appropriate:

• Kidneys • Heart • Liver • Corneas • Lungs •Pancreas •Tissue • Any part of my body

Signature confirming consent to organ donation

_____

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

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NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register

_____ Date

D	D	M	M	Y	Y	Y	Y

For more information, please visit the National Blood Service website www.blood.co.uk

My preferred address for donation is: (*only if different from your current address, e.g. your place of work*)

_____ Postcode:_____

Accessible Information Standard

Please state any specific needs you have so we can ensure they are identified and accommodated for (these include but are not limited to any sensory impairment, use of an Assistance Dog, physical or mental disabilities, access requirements, religious or cultural needs, translator/interpreter requirement, nutritional requirements and phobias):

The Accessible Information Standard aims to ensure that patients (or their carers) who have a disability or sensory loss can receive, access and understand information, for example in large print, braille or via email, and professional communication support if they need it, for example from a British Sign Language interpreter.

This applies to patients and their carers who have information and / or communication needs relating to a disability, impairment or sensory loss. It also applies to parents and carers of patients who have such information and / or communication needs, where appropriate.

Individuals most likely to be affected by the Standard include people who are blind or deaf, who have some hearing and / or visual loss, people who are deaf blind and people with a learning disability. However, this list is not exhaustive.

• Do you have communication needs? **Yes □ No □**

• Do you need a format other than standard print? **Yes □ No □**

• Do you have any special communication requirements? **Yes □ No □**

• How do you prefer to be contacted? _____

_____

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: _____

Health Questionnaire

Please complete the health questionnaire below and return to Sunbury Health Centre Group Practice **with the Registration Form.**

Date of Birth: | D | D | M | M | Y | Y | Y | Y | Surname: _____ First Name: _____

Marital Status:_____

Occupation:_____ _____ Religion: _____

Next of Kin: _____ Relationship: _____ Contact Tel No: _____

Are you registered disabled?* **No / Yes** If yes please state type of disability_____

Do you have a carer?* **No / Yes** Are you a carer?* **No / Yes**

If yes please complete the Yellow Carer Form available from reception.

General Medical History

If you are on regular medication, please make an appointment to see a doctor within 2 weeks. You will not be issued any medication before then.

Serious or Chronic illnesses *(please circle)*

- Blindness
- Glaucoma
- Stroke
- Blood Pressure
- Diabetes
- Heart Attack
- Epilepsy
- Asthma
- Depression
- Cancer

Other serious/chronic illnesses or operations, X-rays or similar tests and when? _____

_____

Height _____ Weight _____

What medicines are you taking (*including Warfarin and the contraceptive pill for females*)?_____

_____

Have you any allergies to medicines or anything else? _____

_____

Have you ever smoked? **Yes** / **No** If Yes, are you now an ex smoker? **Yes / No**

If you are an ex smoker, what year did you stop? _____

If you are a smoker, what is your daily consumption? No of cigarettes _____ Number of Cigars_____ Ounces of pipe tobacco_____

How many units of alcohol do you drink in a week? _____ Please circle if appropriate **Teetotaller / Ex Drinker**

Exercise? (*please circle*) **Exercise Not Possible** **Light Exercise** **Moderate Exercise** **Heavy Exercise**

Health Questionnaire cont'd

Family History

Serious illness in your close family (***please circle***)

- Blindness
- Glaucoma
- Stroke
- Blood Pressure
- Diabetes
- Heart Attack
- Epilepsy
- Asthma
- Depression
- Cancer
- Sudden Death

Female patients only

*please delete as necessary

Have you any children? (*give ages*) _____

Have you had any miscarriages?* **Yes / No** Have you had a termination of pregnancy?* **Yes / No**

Are you pregnant?* **Yes / No** If **Yes**, date of last period?

D	D	M	M	Y	Y	Y	Y

Have you had a hysterectomy?* **Yes / No** If **Yes**, Date?

D	D	M	M	Y	Y	Y	Y

What method of contraception do you use at present? _____

When was your last cervical smear test? _____

Result? _____Where taken and by who? _____

Have you ever had an abnormal smear?* **Yes / No**

Date of last mammogram?

D	D	M	M	Y	Y	Y	Y

Sunbury Health Centre Group Practice – Text Communication Consent Form Declaration

Patients registering with the practice are able to register for our text messaging service for the purposes of health promotion, practice news and for appointment reminders. Appointment reminders by text are an additional service but the responsibility for attending appointments or cancelling them rests with you. You can cancel the text message facility at any time by contacting the practice in writing. Text messages are generated using a secure facility over a public network onto a personal telephone and as such may not be secure, however the practice will not transmit any information which would enable an individual patient to be identified.

If more than one person shares the use of the mobile phone number detailed below, we will need a consent form from each of those people.

By using this form, you will be sending information about yourself across the Internet. Whilst every effort is made to keep this information secure, you should be aware that we cannot offer any guarantees of absolute privacy. If this matter concerns you then you should use another method to notify us of your details.

I agree to the practice communicating with me by Short Messaging Service (SMS or Text) **Yes** □ **No** □

I confirm that the mobile number the practice holds on my record is correct and I will notify the practice of any changes.

I agree to receive a reminder of my appointment by SMS.

I am aware that I can withdraw consent at any time by informing the practice either verbally or in writing.

Patient Name …….

Date of Birth …….

Home Tel …….

Mobile …….

Signature …….

Online Access / Patient Access

What is Patient Access?

With Patient Access, you can now access our GP services at home, work or on the move— wherever you can connect to the internet (if you are 16 or over). What's more, because Patient Access is a 24 hour online service you can do this in your own time, day or night. Patient Access is also available on a mobile app which is free for iOS and Android users. If you register with Patient Access the following facilities are available to you -

- Book a GP appointment
- View your appointments
- Cancel your appointments
- Order repeat prescriptions and check the progress

How do I register?
Confirm you are opting in to the service **Yes** □ **No** □

Come into the practice with Photo ID (passport, driving licence etc) and this form. Once we have processed your registration with the practice and checked your details we will supply you with a letter containing your login codes and a pin.

Is my information secure?

All information that is sent to our surgery via Patient Access is secure. Your personal details are encrypted and protected using the highest standard internet security, so it cannot be intercepted. Only you and your GP surgery are able to see this information.

Please remember to bring your photo ID when you come to the practice to register for this service as we cannot activate your Patient Access account you without it!

Summary Care Record OPT OUT FORM

YOUR NAME: DATE OF BIRTH:

Sunbury Health Centre Group Practice offers its patients the choice of having a Summary Care Record.

The new NHS Summary Care Record has been introduced to help deliver better and safer care and give you more choice about who you share your healthcare information with.

What is the NHS Summary Care Record?

The Summary Care Record contains basic information about:

- **any allergies you may have,**
- **unexpected reactions to medications,**
- **and any prescriptions you have recently received**.

The intention is to help clinicians in A & E Departments and 'Out of Hours' health services to give you safe, timely and effective treatment. Clinicians will only be allowed to access your record if they are authorised to do so and, even then, only if you give your express permission. You will be asked if healthcare staff can look at your Summary Care Record every time they need to, unless it is an emergency, for instance if you are unconscious. You can refuse if you think access is unnecessary.

Children under the age of 16

Patients under 16 years will not receive this form, but will have a Summary Care Record created for them unless their GP surgery is advised otherwise. **If you are the parent or guardian of a child then please either make this information available to them or decide and act on their behalf. Ask the surgery for additional forms if you want to opt them out.**

You do not have to have a Summary Care Record, although you are strongly recommended to consider this choice. If you are happy for a Summary Care Record to be set up for you then you need take no further action. If you want to opt-out now please tick the box below and return it to Reception as soon as possible.

Please tick the box and sign below if you do not want a Summary Care Record:

No I do not want a Summary Care Record ☐ Date_____

Signed_____

Hand this form in at your Surgery if you wish to "Opt-Out"