Barking Medical Group Practice
New Patient Registration Form

Today's Date:

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.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment and utility bill as proof of residence.

Please complete a separate form for each family member to be registered.

<table>
<tr><td colspan="6">Full Name:</td></tr>
<tr><td colspan="4">Mr / Mrs / Miss / Ms / Other……..</td><td colspan="2">Telephone Number:</td></tr>
<tr><td colspan="4" rowspan="4">Address and Postcode</td><td colspan="2">Mobile Number:</td></tr>
<tr><td colspan="2">E-mail Address:</td></tr>
<tr><td colspan="2">Next of Kin:</td></tr>
<tr><td colspan="2">Next of Kin Contact Number:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td colspan="2">Previous / Mother's surname if different:</td><td colspan="2">Town & Country of Birth</td></tr>
<tr><td>Marital Status:</td><td></td><td>Gender:</td><td>Male:</td><td>Female:</td><td>Other residents of your home:</td></tr>
</table>

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):	
Please state any Mental disabilities you have:	
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:	
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.	**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:**

DECLARATION

Patient Authority- Leaving Messages

In accordance with the Data Protection Act. Baking Medical Group needs consent from any patient that has an answer phone and is happy for us to leave a message. If we do not have consent, we will be unable to leave a message on an answer phone or with a 3rd party.

Please complete the appropriate box

☐**I give consent to Barking Medical Group to leave messages on my mobile/SMS**
☐**I do not give consent for the practice to leave messages on my mobile/SMS**
☐**I give consent for the practice to leave message about any aspect of my medical treatment with**

Are you: - Employed ☐ Unemployed ☐ Studying ☐ Retired ☐ Full time parent ☐
Occupation:

ETHNICITY

Please circle the ethnic group, which most closely matches your ethnicity.

(Asian or Asian British) Bangladeshi	☐	(Black or Black British) Other	☐	(White) British	☐
(Asian or Asian British) Indian	☐	(Mixed) Other	☐	(White) Irish	☐
(Asian or Asian British) Other	☐	(Mixed) White and Asian	☐	(White) Other	☐
(Asian or Asian British) Pakistani	☐	(Mixed) White and Black African	☐		
(Black or Black British) African	☐	(Mixed) White and Black Caribbean	☐		
(Black or Black British) Caribbean	☐	(Other) Chinese	☐		

Other ethnicity please specify:-

Main Spoken Language: Do you speak English? YES ☐ / NO ☐

If you have difficulty communicating in English, we do strongly recommend you provide us with somebody that can help translating. This would make phone consultations possible, speed up appointments offered and future contact/reviews.

RELIGION

Please circle the ethnic group, which most closely matches your ethnicity. This information is used to plan provision of our services e.g. advocacy services.

Catholic ☐	Jewish ☐	Hindu ☐	Buddhist ☐
C of E ☐	Muslim ☐	Sikh ☐	No religion ☐

Other Christian (state): Other religion (state):

MEDICAL HISTORY

Have you been diagnosed with any of the following?

Diabetes ☐ Asthma ☐ High Blood Pressure ☐ Chronic bronchitis ☐ Gastritis ☐
Heart Disease ☐ High Cholesterol ☐ Stroke ☐ Epilepsy ☐ Rheumatoid ☐ arthritis ☐

Please complete form bellow if you have had any of the conditions above or any other major conditions

Condition	Year diagnosis	Treatment

Any major previous surgeries?, please complete form bellow

Surgery	Year	Any current problems

FAMILY HISTORY

Has anyone in your immediate family had any of the following?

High Blood Pressure ☐ High Cholesterol ☐ Diabetes type 2 ☐

Asthma ☐ Heart Disease ☐ Stroke ☐

Breast cancer ☐ Bowel cancer ☐

WOMEN ONLY

When was your last smear Where was it taken Result

Have you ever had an abnormal smear Yes ☐ / No ☐ Date: Result

Were you treated in the colposcopy clinic? Yes ☐ / No ☐

BLOOD TESTS

When was your last blood test and reason?

Are you due any blood tests?

MEDICATIONS

Do you take any regular medication? Yes ☐ / No ☐

By giving us the name and dose may facilitate issuing you a prescription before your records arrive

Name	Dose	Frequency	Reason

Are you allergic to any medication? Yes ☐ / No ☐ Which ones?

SMOKING

Do you smoke? Yes ☐ / No ☐ If Yes how many per day:

Ex-Smoker? Yes ☐ /No ☐ How many years did you smoke for? Average of cigarettes per day

ALCOHOL

How often do you have a drink that contains alcohol: Never ☐ Monthly ☐ 2-4 times week ☐ 4 + week

Recent Measurements: please state dates.

Weight Height

Blood Pressure Pulse

HOW MUCH EXERSICE DO YOU TAKE

None ☐	Walking less than 30 minutes per day
Light ☐	Walking 30-60 minutes per day
Moderate ☐	Cycling / swimming / tennis 3x/week
Heavy ☐	Running, gym aerobics, football more than 3 hours per week

Summary Care Records.

The NHS are 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. An information pack has been provided.

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:**	

<u>Patients 16 and over</u>; Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice)
The Consultation will also establish relevant past medical and family history.

Thank you for completing this form

For more information about the services we offer, please refer to your new patient leaflet or see our website: http://www.barkingmedicalgroup.co.uk/