TRINITY MEDICAL CENTRE – New patient registration form

Please complete this questionnaire and return it to the surgery with your GMS1 registration document, photo ID and a recent proof of address.

Surname: ……

First Name(s): ……

Previous Surnames (if applicable): ……

Date of Birth:……

Sex: *Please tick*: [ ] Male [ ] Female [ ] Transgender [ ] Other [ ] Prefer not to say

Contact Details:

Home: …… Work: ……

Mobile: ……

Email: ……

Nominated Pharmacy (prescriptions to be sent electronically to): ……

Ethnic Origin: *Please tick*

( ) African
( ) Bangladesh/British Bangladesh
( ) British/Mixed British
( ) Caribbean
( ) Chinese
( ) Ethnic Category not stated
( ) Indian/British Indian
( ) Irish
( ) Other Asian Background
( ) Other Black Background
( ) Other Mixed Background
( ) Other White Background
( ) Pakistani/British Pakistani
( ) White and Asian
( ) White and Black African
( ) White and Black Caribbean

Do you need an interpreter? *Please tick*: [ ] Yes …….. [ ] No
(If yes, please note language here)

Do you have any communication/information needs relating to a disability, impairment or sensory loss? *Please tick:* [ ] Yes [ ] No
If "yes", what are those needs? ……

Do you have a main carer or are you the main carer for a vulnerable person?
Please tick. [ ] Yes [ ] No

If "yes" please provide detail: ……

Are you housebound? Please tick: [ ] Yes [ ] No

Do you suffer from any drug or other allergies? *Please tick*: [ ] Yes [ ] No

If "yes" please give details: ……

……

ABOUT YOUR FAMILY - Has any member of your family had any of the following?:

Condition	Relationship
Heart Problems	
Stroke / CVA	
Diabetes	
Asthma	

Please record your current **Height**: ……**cm** **Weight**: …… **Kg**
You are welcome to use the scales available at the surgery if no other scales are available to you.

PLEASE TAKE YOUR BLOOD PRESSURE USING ONE OF THE MACHINES AVAILABLE AND RECORD IN THE BOX BELOW:

Smoking Status: *Please tick*: **Current** [ ] **Ex – smoker** [ ] **Never** [ ]
If you are a current smoker, how many per day (approx): ……..

Alcohol (average units per week): ……..

Next of Kin details: Name: ……

Relationship…….. **Contact:** ……..

Occasionally it may be necessary for the surgery to contact you, *please tick* whether you're happy for us to contact you via:

Home Phone [ ] Mobile [ ] Text [ ] Email [ ]

Do we have consent to leave voicemails on your mobile [ ] / home phone [ ]?

(This arrangement will remain in force until you advise us that you wish to change it.)

Summary Care Record:
An NHS SCR is a summary of clinically important information (e.g. medications, allergies etc) about a patient. A summary is created from your GP records and can be used by authorised NHS healthcare professionals (e.g. in A&E departments or walk in centres), with your consent, to support care and treatment that may be needed.
Please tick:
[ ] **Yes – I wish to have a summary care record (you will not need to do anything more)**

[ ] **No – I do not wish to have a summary care record.** If you have ticked no you will have to complete an "opt-out" form which you can collect from reception (if you do not complete this form you will have been considered to have opted in).

You can get more information about the Summary Care Record from Reception.

Please note: We do not automatically carry out "new patient health checks" at this surgery. If you feel you need to see / speak with a clinician please contact the surgery during opening times to arrange a suitable appointment.

Thank you for taking the time to complete this form.

For office use only:

ID/Proof of address seen: ……..

Date form handed in: ……..

Member of staff to check form: ……