

# New Patient Questionnaire

UNDER 16'S

Stony Medical Centre

If you need any support completing these forms please ask our reception teams who will be happy to help you. Please ensure you complete the Purple GMS (General Medical services) form clearly at the front of this leaflet.

You can obtain your NHS number from your previous GP surgery.

We do understand that not all questions on our registration forms are applicable to all patients. However it is important we use the registration process to capture as much information as possible. This is to ensure that we are offering you the best standard of care and can signpost patients who may need extra support at the point of registration. Please complete the registration forms to the best of your knowledge with as much information as possible.

<b>PATIENT NAME:</b> .....	<b>DOB:</b> .....
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We recommend that patients provide identification when registering at the practice. If you're unable to provide identification we can still register you. However you won't be able to access our online services without proof of identification.

**We do recommend patients sign up for online services.**

Have you been registered with our GP Practice before? Yes  No

If you have previously been de-registered under our zero-tolerance scheme you must not register with our practice, without first writing to the Practice Manager with your request. If the practice declines your request to register they will inform you in writing of the decision. The practice has a right to remove your registration at their discretion at any time if you have previously been removed from our list for abusive behavior and not informed them at the point of re-registering.

### ONLINE PATIENT SERVICES:

I wish to have access to the following online services (please tick all that apply):

- 1. Booking appointments
- 2. Requesting repeat prescriptions
- 3. Accessing my medical record

**Please provide photographic identification and proof of address to register with our online services.**

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<b>CONTACT DETAILS:</b> Mobile No:.....	Work No:.....
Telephone No:.....	Email address:.....
Consent for SMS messages Do you consent to us contacting you by SMS messages Yes <input type="checkbox"/> No <input type="checkbox"/>	Consent for email correspondence Do you consent to us contacting you by email correspondence Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>NEXT OF KIN:</b> Name:.....  Address (including postcode):.....  Contact number:.....  Your relationship:.....	
<b>PHARMACY CHOICE:</b> Name and address of Nominated Pharmacy for prescriptions:.....	
<b>SUMMARY CARE RECORD:</b> Your records will automatically be coded for an Enhanced summary Care record. If you do not want a summary care record, please ask at reception for an OPT out form and tick here <input type="checkbox"/> Your Summary Care Record is a short summary of your GP medical records. It tells other health and care staff that care for you about the medicines you take and your allergies. It means they can give you better care if you need health care away from your usual doctor's surgery: for example, in an emergency, when you're on holiday, when your surgery is closed, at out-patient clinics or when you visit a pharmacy.	
<b>THIRD PARTY ACCESS:</b> In the Practice we aim to provide you with the highest quality of healthcare. To do this we must keep records about you, your health and the care we have provided or plan to provide to you. Everyone working for the NHS has a legal duty to keep information about you confidential. If you would like a family member or carer to have access to your medical records on your behalf we need to keep their contact details on your records. The person you nominate must be happy to have their details recorded in your medical records. If you wish to nominate someone for this reason please provide us with their details and sign below that you consent to this Name of nominated individual .....  Your signature ..... Date .....	

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**MAIN SPOKEN LANGUAGE:**

English (please tick) <input type="checkbox"/>	Other (please state): .....
Do you require an interpreter: Yes <input type="checkbox"/> No <input type="checkbox"/>	

**ETHNICITY:**

British <input type="checkbox"/>	Irish <input type="checkbox"/>	Other White <input type="checkbox"/>	Mixed <input type="checkbox"/>	Indian <input type="checkbox"/>	Pakistani <input type="checkbox"/>
Bangladeshi <input type="checkbox"/>	Other Asian <input type="checkbox"/>	Caribbean <input type="checkbox"/>	African <input type="checkbox"/>	Other Black <input type="checkbox"/>	Chinese <input type="checkbox"/>

**LIFESTYLE:**

Blood pressure reading (please use pod in reception if available )	
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**HEIGHT/ WEIGHT:**

Height (In meters):	Weight (In kg):
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**SMOKING STATUS:**

Never smoked tobacco <input type="checkbox"/>	Ex- smoker <input type="checkbox"/>	Smoker <input type="checkbox"/>
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**IF YOU ARE A SMOKER PLEASE ANSWER/TICK THE FOLLOWING:**

Daily cigarette consumption:	
Pipe smoker <input type="checkbox"/>	User of electric cigarette <input type="checkbox"/>
Rolls own cigarettes <input type="checkbox"/>	Drug smoker <input type="checkbox"/>
Would like help to stop smoking <input type="checkbox"/>	Not interested in stopping smoking <input type="checkbox"/>

**PERSONAL MEDICAL HISTORY (Please tick relevant boxes and date of diagnosis):**

Angina <input type="checkbox"/>	Arthritis <input type="checkbox"/>	Asthma <input type="checkbox"/>
Diabetes <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Hypertension <input type="checkbox"/>
Learning Disability <input type="checkbox"/>	Osteoporosis <input type="checkbox"/>	Mental Health <input type="checkbox"/>
Skin Disorders <input type="checkbox"/>	Thyroid Disorder <input type="checkbox"/>	History of COPD <input type="checkbox"/>
Cancer <input type="checkbox"/>	Other (please state) .....	

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## FAMILY HISTORY:

Heart problems <input type="checkbox"/> Relationship & age .....
Stroke (CVA) <input type="checkbox"/> Relationship & age .....
Cancer <input type="checkbox"/> Relationship & age .....
Diabetes <input type="checkbox"/> Relationship & age .....
Asthma <input type="checkbox"/> Relationship & age .....

## REPEAT MEDICATION:

If you are taking regular medication from your previous GP you will need to book an appointment before GP's can issue this, please allow yourself plenty of time so you do not run out of medication and bring along previous prescription requests/ medication with you to your appointment.

Please note we do not accept prescription requests over the phone unless you are housebound. Prescriptions take 48-72 hours to be processed.

## SENSITIVITIES/ ALLERGIES:

Please advise us of any sensitivities or allergies ..... .....
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## CARERS:

Are you a carer for someone? Yes <input type="checkbox"/> No <input type="checkbox"/>
Is there someone that you rely on for your care? Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have carer support? Yes <input type="checkbox"/> No <input type="checkbox"/>
If you have ticked yes would you like to be referred to carers MK? Yes <input type="checkbox"/> No <input type="checkbox"/>

## LOOKED AFTER CHILDREN:

Are you a looked after child? Yes <input type="checkbox"/> No <input type="checkbox"/>
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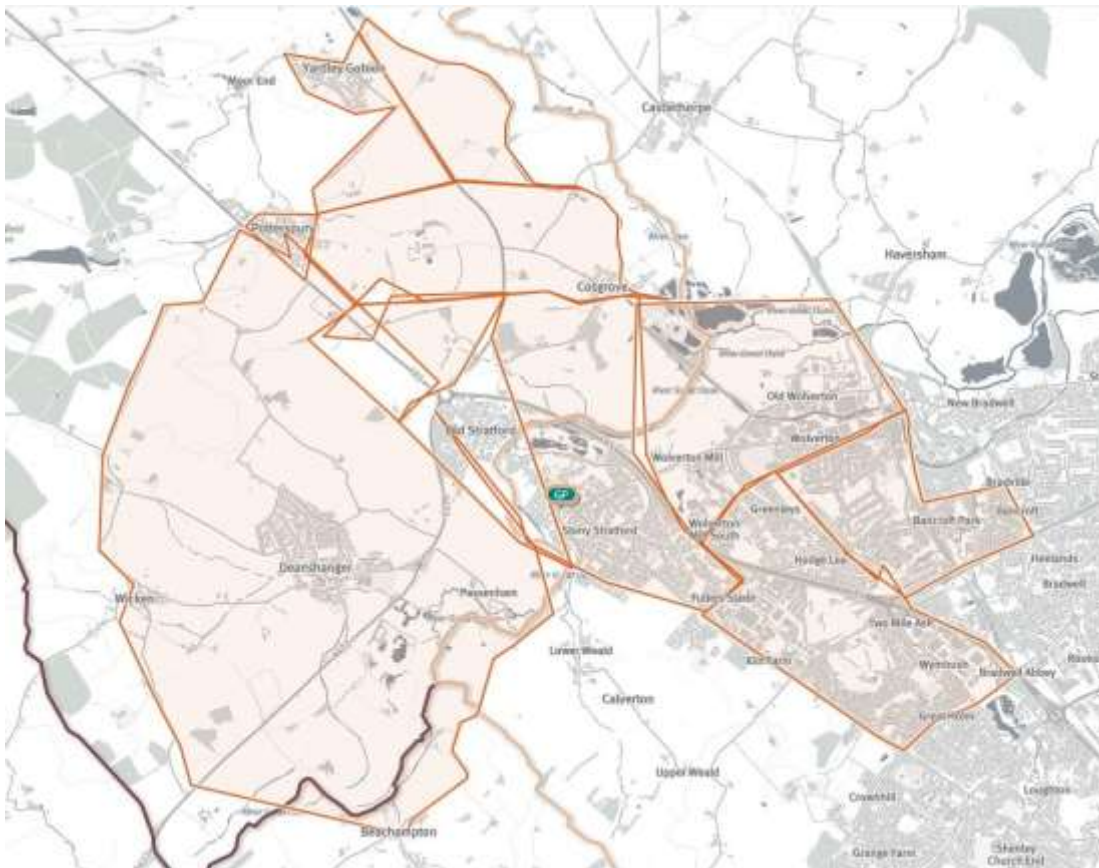
Stony Medical Centre

**COMMUNICATION:**

We want to make sure you can read and understand the information we send you. If you find it hard to read letters or if you need someone to support you at appointments, please let us know in the answers given below.

Hearing impairment- please answer below if you have a hearing impairment	Visual impairment- please answer below if you have a visual impairment
Do you lip read <input type="checkbox"/>	Do you need information in a different format <input type="checkbox"/>
Do you wear a hearing aid <input type="checkbox"/>	If so please tick below what format you need it in:
Areas of difficulty with hearing, other..... .....	20 point sans serif font <input type="checkbox"/>
Is an interpreter needed, i.e. British Sign Language <input type="checkbox"/>	24 point sans serif font <input type="checkbox"/>
	28 point sans serif font <input type="checkbox"/>
	Requires information in electronic downloadable format <input type="checkbox"/>

**You can only register at our practice if you live within the catchment area for our practice. Please only submit your registration if you live within the areas below – IF you have completed this form and do not live in our boundary area you can take this form to any surgery in Milton Keynes close to your home address**  
**Practice Boundary area map**



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## CONSENT

I consent to the practice contacting me by text message and/or email message for the purposes of health promotion and for appointment reminders.

I acknowledge that appointment reminders by text and/or email are an additional service and that these may not take place on all/or on any occasion and that the responsibility of attending appointments or cancelling them still rests with me. I can cancel the text and/or email message facility at any time.

Text messages are generated using a secure facility however I understand that they are sent 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.

I agree to advise the practice if my email address changes and also if my mobile telephone number changes or if this is no longer in my possession.

**The practice does not share mobile phone contact details or email addresses with any external non-NHS organisation.**

**Your medical records may be used for financial or clinical audit, post payment verification checks, medical research or education purposes.**

Signature	Date
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I confirm that the information given above is accurate to the best of my knowledge and that I live within the practice boundary catchment area as detailed in this pack and I confirm that I have read and understood the **Contract of care** provided in this pack.

Signature	Date
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## **CONTRACT OF CARE**

The GPs, Nurses, Practitioners and Staff aim to provide the highest possible care to our patients. The aim of this Contract of Care is to ensure that you understand the practice policies, why such policies are in place and then follow them. We particularly recommend that you read closely the details relating to our Appointment, Repeat Prescribing and Behaviour expectations.

<b>Your responsibilities:</b>	<b>Practice responsibilities:</b>
Comply with recommended treatment	Offer access to quality medical services
Participate in appropriate screening and prevention programmes	Provide you with an appointment with a GP or appropriate healthcare professional or signpost you to a suitable alternative service in line with our appointments procedure
Commit to a healthy lifestyle with support from the Practice if required	Enable you to relevant appointments with the right clinician the first time
Treat clinicians and staff with dignity and respect at all times	Treat you with dignity and respect at all times.
Be aware of our practice booking system and use this appropriately and book with the appropriate clinician	Ensure all patients have access to a patient information leaflet which includes information of how to book an appointment

Information about all the services we provide are detailed on our website. If you do not have access to the internet please ask at reception for a practice leaflet. Before deciding that you wish to join the Practice we ask that you review this information in order to decide whether you can follow the policies presented by the Practice in line with the General Medical Services GP contract.