

Frome Medical Practice Registration Form EMIS No: _____

Form Taken in by: _____ Date : _____

You will be registered with Doctor: _____



Frome
Medical Practice
SUPPORTING YOUR HEALTH

Please fill in the patient's details below and return the form to us. Please let us know if any of these details change in the future. All forms must be completed where necessary. Please tick the boxes on this form that apply to the patient.

Male Female

Mr Mrs Miss Ms

First name: _____

Middle name: _____

Surname: _____

Previous surname: _____

Date of birth: _____

NHS no: _____

Where were you born? Town: _____

Country: _____

Home Address: _____ Tick if you are homeless:

Town: _____

County: _____

Postcode: _____

Home telephone number: _____

Tick box if:

No home telephone

Work telephone number: _____

No work telephone

Mobile telephone number: _____

No mobile telephone

Please let us know if you do not wish to use the SMS text reminder service

Email address: _____

Please provide an email address if you would like to use our email service for your direct care

Who is your next of kin (who do we contact in an emergency)? :

Full Name: _____

Date of Birth: _____

Telephone number: _____

Relationship to you: _____

Are they a Frome Medical Practice Patient ? Yes No

If you are filling this in for a child please tell us who has parental responsibility:
(Please ask us if you need more details about this)

Name: _____

Telephone number: _____

If you are filling this in for a baby, please tell us the name of the Mother's Doctor:

Mother's Doctor's Name: _____

Please tick your ethnic group in the list below:

(We need this information by law)

White - British White – Other

Black-Caribbean Black - Other

Asian Other

Do you need a language interpreter?

What is your first choice language? _____

Consent given for carer or family member to interpret ?

Signature: _____ **Date:** _____

Please tick this box if you are signing on behalf of the patient:

Please note – Previous address and Doctors MUST be completed

unless the form is for a New Born Baby. For new babies please go to Pages 8 and 9.

Your last United Kingdom (UK) address:

Town: _____

County: _____

Postcode: _____

Your last UK doctor's name and address: (we need this to find your records)

Doctor's Name: _____

Surgery address: _____

Town: _____

County: _____

Postcode: _____

If you are from abroad and have not lived in the UK before:

Date you entered the country: _____

Is this your first UK doctor's registration? Yes No

If you have registered with a UK doctor before, please fill in the last doctor's name and address details above

If you are returning from living abroad and have lived in the UK before:

Date left the UK: DD/MM/YYYY _____

Date returned to the UK: DD/MM/YYYY _____

Address: (where did you live before you left the UK?)

Town: _____

County: _____

Postcode: _____

Your last UK doctor's name and address: (before you left the UK)

Name: _____

Surgery address: _____

Town: _____

County: _____

Postcode: _____

If you are returning from the Armed Forces

Service no:	_____
Date you joined the forces:	_____
Date you left:	_____
Where you lived before joining the forces?	_____ _____
Town:	_____
County:	_____
Postcode:	_____
Name and address of your Last doctor before joining the forces: (Needed to find your records)	
Doctor's Name:	_____
Surgery address:	_____ _____
Town:	_____
County:	_____
Postcode:	_____

Are you a military veteran?

Force Served: Army RAF Royal Navy

NHS organ Donation

If you wish to become an organ donor please visit this website and register:
<https://www.organdonation.nhs.uk/> or call 0300 123 23 23

NHS blood donor

If you wish to give blood please visit this website and register
<https://www.blood.co.uk/> or call 0300 123 23 23

To help us to provide you with better all-round healthcare, it would be useful if we could find out some basic information about you.

What is your height in centimetres? _____

What is your weight in kilograms? _____

Please complete if you are over 16

How often do you have a drink containing alcohol?

- Never
- Monthly or less
- 2-4 times per month
- 2-3 times per week
- More than 4 times per week

How many units of alcohol do you drink on a typical day when you are drinking? If you are not sure what a unit of alcohol is please ask us or visit the www.drinkaware.co.uk website.

- 1-2
- 3-4
- 5-6
- 7-8
- More than 10

How often have you had 6 or more units (if female) or 8 or more units (if male) on a single occasion in the last year?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

Do you smoke? How many a day? _____
Are you an ex-smoker? Date you gave up: _____
Never smoked

Examples of Alcohol Units



PINT CIDER: ABV 5.3%
3 UNITS



RED WINE (125ML): ABV 12.5%
1.6 UNITS



SAMBUCA SHOT: ABV 42%
1 UNIT



BOTTLE LAGER: ABV 5.2%
1.7 UNITS



ALCOPOP: ABV 5%
1.4 UNITS



HALF PINT CIDER: ABV 5.3%
1.5 UNITS



SINGLE GIN & TONIC: ABV 40%
1 UNIT



DOUBLE COGNAC: ABV 40%
2 UNITS



CHAMPAGNE (175ml): ABV 11.5%
2 UNITS



DOUBLE WHISKY & COKE: ABV 40%
2 UNITS



HALF PINT LAGER: ABV 5.2%
1.5 UNITS



COSMOPOLITAN COCKTAIL
2 UNITS



PINT BITTER: ABV 5%
2.8 UNITS



ALCOPOP: ABV 5%
1.4 UNITS



PIMMS: ABV 25%
1.3 UNITS



DOUBLE WHISKY: ABV 40%
2 UNITS



WHITE WINE (175ml): ABV 13%
2.3 UNITS



PINT LAGER: ABV 5.2%
3 UNITS



BOTTLE OF WINE: ABV 13.5%
10 UNITS

Have any of your direct family members suffered from:

Angina or a heart attack BEFORE the age of 60 (please circle)

Yes No

If so, what is their relationship to you? _____

A stroke or TIA (mini stroke) (please circle)

Yes No

If so, what is their relationship to you? _____

Diabetes (please circle)

Yes No

If so, what is their relationship to you? _____

Do you exercise regularly?

- Yes – heavy exercise regularly
- Yes - moderate
- Yes - light
- No
- No – exercise is impossible for me

Hearing and Vision

Are you:

- Profoundly deaf
- Registered blind
- Low vision, both eyes

Do you have an advanced decision to refuse treatment (previously known as an advance directive or living will)?

If so please tick the box below and let us have a copy to add to your record.

Yes No

More details about advance decisions can be found on the Age UK website – www.ageuk.org.uk

Accessible Information: to be completed by everyone including for new babies. Please tell us if your **needs** change in the future.

Do you need us to contact you in a certain way? (Examples include using the text relay service, by letter only or by telephone only, via your carer only etc.)

No (I can accept BOTH standard letters AND telephone calls)

Yes (please provide details below):

If you need us to ONLY contact you via your carer please fill in carer details below:

Carer's Name: _____

Carer's Address: _____

Town: _____

County: _____

Postcode: _____

Telephone: _____

Relationship to you: _____

Is this your main carer? Yes No

Is this a professional carer? Yes No

Have you been diagnosed with dementia? Yes No

For office use - (If unpaid carer, please pass details to carers champion. For professional carers please add details to patient registration family relationship links and add carers alert)

Do you need professional communication support or an interpreter?

(Examples include carer support, British Sign Language Interpreter, note taker etc.)

No

Yes (please provide details below):

Do you need support to communicate or use a communication aid?

(Examples include need a longer appointment, need an audible or visual alert, use a hearing aid, lip reads etc.)

No

Yes (please provide details below):

Do you need information in a format other than the standard written format?

(Examples include verbally, in large print, in easy read format etc.)

No

Yes (please provide details below):

If you have identified information or communication needs above please answer the following question:

Are you a Carer or parent of a dependent child?

Parent Carer

If you are a **Carer**, please complete the **carer's details at the end of this form**.

If you are a **parent**, please give details of your **dependent children below**:

Person 1 Name: _____

Address: _____

Town: _____

County: _____

Postcode: _____

Relationship to you: _____

Person 2 Name: _____

Address: _____

Town: _____

County: _____

Postcode: _____

Relationship to you: _____

Carers

Britain has seven million unpaid carers who look after a relative or friend who cannot manage at home.

Are you an unpaid Carer?

Yes No

Your name: _____

Date of birth: _____

If you are an unpaid Carer, please give details of the **person you care for**:

Name: _____

Address: _____

Town: _____

County: _____

Postcode: _____

Telephone Number: _____

Relationship to you: _____

Are you the main unpaid carer? Yes No

Has the patient you care for been diagnosed with dementia?

Yes No

If you are an unpaid carer we would like to add your name to our register of carers. Once you are registered we can offer you more help and advice like health checks, flu injections and appointments to fit in with your caring role where we can.

If you are happy for us to add you to our register of carers please sign below. We will then write to the person you are caring for because they also need to let us know that they are happy for you to be registered as their carer on their medical record.

Signature: _____

Date: _____

Do you have an unpaid Carer?

Yes No

Your name _____

Date of birth: _____

If you have an unpaid Carer, please give their name and contact details:

Carer's Name: _____

Carer's Address: _____

Town: _____

County: _____

Postcode: _____

Carer's Telephone Number: _____

Relationship to you: _____

Have you been diagnosed with dementia: Yes No

Sometimes it is helpful for us to talk to your carer about your current and past health issues (medical history) and your medication, but we will only do this if you tell us that you are happy for us to do this.

If you are happy for us to do this, please tick the boxes and sign below:

I am happy for you to talk about my medical history with my carer named above if it relates to my current health problem.

I am happy for you to talk about my medication with my carer named above if it relates to my current health problem

I am happy for you to contact my carer to ask if they would like to be added to our register of carers

Signature: _____

Date: _____

We have a Carer's Champion who can give you help and advice if you are a Carer. Please ask at the Information Desk for more information.