Frome Medical Practice Registration Form

Form Taken in by: ___________ Date : ____________

You will be registered with Doctor: _____________________ _ EMIS No: _________

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 THE FORM 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: ____

Tick box if:

Home telephone number: __________________ ☐ No home telephone

Work telephone number: __________________ ☐ No work telephone

Mobile telephone number: __________________ ☐ No mobile telephone

Please let us know if you do not wish 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)

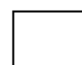
White - British	☐	White – Other	☐
Black-Caribbean	☐	Black - Other	☐
Asian	☐	Other	☐

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/YYY ______________________________

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:

www.uktransplant.org.uk or call 0300 123 23 23

NHS blood donor

If you wish to give blood please visit this website and register www.my.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

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

Do you smoke? ☐ How many a day? ________________

Are you an ex-smoker? ☐ Date you gave up: ________________

Never smoked ☐

<u>Have any of your direct family members suffered from</u>:

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

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? (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: ____________________

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

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.