The Hall Practice

Hampden Road, Chalfont St. Peter, Buckinghamshire, SL9 9SX
Telephone: 01753 989800
www.thehallpractice.co.uk

NEW PATIENT REGISTARTION FORM (ADULT)

TODAY'S DATE:

Please complete this confidential questionnaire.

Please complete in **BLOCK CAPITALS** and **tick the boxes as appropriate**.

Please complete a separate form for each family member to be registered at The Hall Practice.

If you have been registered with NHS before, please let us know your NHS number and the name and address of the GP you were registered with.

PATIENT CONTATC DETAILS

Full Name:			**Home Number:**
NHS Number:	**Title:**		**Work Number:**
Address and Postcode:		**Email Address:**	**Mobile Number:**
I agree to receive communications via test messages: Yes / No			
I agree to receive communications via email: Yes / No			
Date of Birth:	**Previous/Mother's Surname if different:**		**Town and Country of Birth:**
If applicable, date you first came to live in England:			
Marital Status:	**Gender:**		**Occupation:**
Next of Kin:	**Next of Kin relationship to you:**		**Next of kin contact:**
Emergency Contact *(if different than your next of kin)* Name and Contact Details:			
Other residents of your home:			
Names and Date of Birth of Children:			

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Previous Address and Postcode:				**Previous GP Surgery Name & Address:**		
Have you ever been in the armed forces? Yes / No				**Length of Service:**		
Your religion: (please select one)	**Buddhist**	**Catholic**	**Church of England**	**Other Christian (state)**	**Hindu**	**Jehovah's Witness**
	Jewish	**Muslim**	**Sikh**	**No religion**	**Other (state)**	

Your Ethnic Origin: (please select one)	**African**	**Asian**	**Bangladeshi/ British Bangladeshi**
Caribbean	**Chinese**	**Indian/ British Indian**	**Pakistani/ British Pakistani**
White (UK)	**White (Irish)**	**White (Other)**	**Other Asian Background**
Other Black Background	**Other Mixed Background**	**Other (please specify)**	**Ethnic Category Not Stated**

Your main or 1st language (please select one)	**English**	**Hindi**	**Gujurati**	**Urdu**	**Bengali/Sytheti**	
Punjabi	**Polish**	**Ukrainian**	**French**	**German**	**Spanish**	**Portuguese**

Other language: (please specify)	**Translator Required? Yes / No**

Summary Care Records

The NHS is 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.

Are you happy to have a Summary Care Record	**Yes**	**No**	**More time to decide**

Consent to Access Medical Records

The Hall Practice holds medical records relating to the treatment and services patients receive from their GP. We are asking permission for these records to be looked at by external auditors assessing quality of care if the need should arise. We support these checks, as they are an important part of ensuring quality and efficiency of care and treatment in the NHS. The auditors who carry out these checks are bound by the strict rules of confidentiality and your records will only be used for the purpose described.

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PLEASE TICK IF YOU WISH TO OPT OUT		
Prescriptions		
There is now the facility to nominate a chemist for your prescription to be generated electronically. Please nominate a pharmacy to collect your prescription from. Please note you will still need to have to order your prescription from the surgery or your chemist.	**Boots (Gerrards Cross)**	
	Health & Beauty	
	Richard Adams	
	Vantage	
	Other:	

Lifestyle Questionnaire: ***(please complete)***					
Your Height:	**Feet/Inches**	**Cm**	**Your Weight:**	**Stones/lbs.**	**Kg**
Are you currently a smoker?	**Yes**	**No**	**Have you ever been a smoker?**	**Yes**	**No**
If you currently a smoker, please indicate how many cigarettes/cigars/tobacco do you smoke in a week?					
If you are a smoker and want to stop, please ask for information about local smoking cessation services.					
How much alcohol do you drink in a week (units)? *(One unit = 1 small glass of wine, a single measure of spirits or half a pint of beer)*					
How would you describe your diet?					
Good (i.e. low sugar/salt/fat intake/high in fruit/vegetables/fibre)		**Average**		**Poor** (i.e. high sugar/salt/fat intake/high in fruit/vegetables/fibre)	

How often do you exercise? *Number of times per week*		
Type(s) of exercise:		

Your Medical Background	
Specific Needs **Please detail below any specific needs you have so we can ensure they are identified and accommodated by taking the appropriate action.**	
Please state any sensory impairment *(i.e. speech, hearing, sight)*	
Are you an 'Assistance Dog' user?	
Please state any physical disabilities you have:	

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Please state any learning/psychological disabilities you have:		
Please state any requirements you have, to be able to access the practice premises:		
Please state any cultural or religious needs:		
Do you require the help of a translator/interpreter?		
Please state any phobias you have:		
If you are a carer, please state the name/address/phone number of the person you care for:	Person cared for contact details	
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 next consultation, or leave a copy with reception team.***
Have you nominated someone to speak on your behalf? (e.g. a person who has Power of Attorney for your health)	**Yes / No**	***If 'Yes' please state their name, address and contact details.***

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Women Only			
When was your last smear done? *(if applicable)*	**Date:**	**Was this at your last GP surgery?**	**Yes / No**
What was the result of your last smear?			
When was your last mammogram done? *(if applicable)*	**Date:**	**Method of contraception:** *(if used)*	
Do you wish to see a doctor in this practice for contraceptive services? *(including pill, coil or cap)*			**Yes / No**

Patient Participation Group (PPG)

The practice is committed to improving the services we provide to our patients. To do this, it is important that we hear from people about their experiences, views and ideas for making services better. By sharing your experiences, you will be helping us to tailor our services to meet the patients needs effectively. Being part of the PPG also means we can keep you informed of the practice news and developments.
If you interested in getting involved, please tick the box below and confirm your email address.

Yes, I am interested in becoming involved in The Hall Practice Patient Participation Group (PPG) group. *(please tick the 'Yes' Box)*	**Yes** ☐
Patient Email Address:	

Patient Signature:	
Signature on behalf of the patient:	

Thank you for completing this form.

We will contact you once your registration has been processed.

For more information about the services we provide, please visit our website
www.thehallpractice.co.uk

You can also follow us on Facebook
www.facebook.com/thehallpracticenhs/