Dr H R Furn Davies & Partners – MANN COTTAGE SURGERY
New Patient Registration Form

Please complete this confidential questionnaire

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

PLEASE BRING PROOF OF IDENTITY I.E. PASSPORT/DRIVING LICENCE AND PROOF OF ADDRESS I.E. UTILITY BILL/BANK STATEMENT

If new to the country you will need proof of eligibility for NHS treatment.

Please complete a separate form for each family member to be registered.

<table>
<tr><td colspan="4">Full Name:</td><td colspan="3">Telephone number:</td></tr>
<tr><td colspan="4">Mr / Mrs / Miss / Ms / Other……..</td><td colspan="3">Work telephone number:</td></tr>
<tr><td colspan="4">Address and Postcode:</td><td colspan="3">Mobile number:

Do you consent to receiving text messages from the Practice? This may include general Practice information i.e. flu clinic dates, health promotion etc. YES / NO</td></tr>
<tr><td colspan="4">Next of Kin name , relationship & contact no.:

Are you happy for us to contact this person in the case of an emergency? YES / NO</td><td colspan="3">E-mail Address:

Do you consent to receiving general Practice information i.e. Newsletters, health promotion, notice of flu clinics etc, by email? YES / NO</td></tr>
<tr><td colspan="2">Date of Birth:</td><td colspan="2">Any previous names if different:</td><td colspan="3">Town & Country of Birth:</td></tr>
<tr><td>Marital Status:</td><td></td><td>Gender:</td><td>Male:</td><td>Female:</td><td colspan="3" rowspan="2">Please list ALL residents of your home and give ages of children (if applicable):</td></tr>
<tr><td colspan="5">Previous address and postcode:</td></tr>
<tr><td colspan="5">Previous Doctor name, address and telephone no:</td><td colspan="3">NHS Number (if known)

If you are from abroad, date you first came to live in Britain:</td></tr>
<tr><td colspan="5">Are you an Armed Forces Veteran? YES / NO</td><td colspan="3">Which Armed Service?

When did you leave the Armed Service?</td></tr>
<tr><td colspan="2">Your height:</td><td>Feet / inches OR cm</td><td colspan="2">Your weight:</td><td colspan="2">Stones / lbs. OR kg</td></tr>
<tr><td>Your Religion: (optional)</td><td colspan="6"></td></tr>
</table>

Your Ethnic Origin: (please tick one box)	**White (UK) 9i0**	**White (Irish) 9i1%**	**White (Other) 9i2%**
Caribbean 9i3	**African 9i4**	**Asian 9i5**	**Other Mixed Background 9i6%**
Indian / Brit Indian 9i7	**Pakistani / Brit Pakistani 9i8**	**Bangladeshi / Brit Bangladeshi 9i9**	**Other Asian Background 9iA%**
Other Black Background	**Chinese 9iE**	**Other 9iF%**	**Ethnic Category not stated 9iG**

Your main or 1st language spoken /understood:

Smoking, Alcohol Consumption and Exercise:

Are you currently a smoker?	**Yes**	**No**	**Have you ever been a smoker?**	**Yes**	**No**

If yes, how many cigarettes / cigars / tobacco do you smoke each day?		**How much alcohol do you drink in a week (Units)?** *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)*	
If you are a smoker and want to stop, please ask for information about local smoking cessation services.			

How often do you exercise? No. of times per week		**Type(s) of exercise:**	

Your Medical Background:

What illnesses have you had & when (with dates if possible)?		
What operations have you had and when (with dates if possible)?		
Do you have any medical problems at present? Please give details		
Please list any medications you are currently taking: (incl. dose and frequency, or attach current repeat medication list)		
Are you able to administer your own medicines?	**Yes** *tick*	**No – please detail specific issues (e.g. swallowing, opening containers)**
IMPORTANT: Please state any allergies, adverse reactions and sensitivities you may have:		

Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)	**Diabetes**	**Heart Attack**	**Heart attack under age of 60**	**Bowel Cancer**	
	Breast Cancer		**High Blood Pressure**	**Asthma**	**Stroke**
	Thyroid Disorder		**Any other important Family Illness?**		

Specific Needs:

Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:

Please state any sensory Impairment you have (i.e. speech, hearing, sight):		
Are you an 'Assistance Dog' user?	**YES / NO**	
Please state any physical/mental disabilities you have:		
Do you need any additional support whilst visiting the Practice?	**YES / No – if yes please give details:**	
Please state any Religious or Cultural needs:		
Do you require the help of a translator / interpreter?		
If you are a Carer, please state the name / address / phone number of the person you care for:	**Person Cared For Contact Details:** **Please check that the person is happy to be contacted in an emergency should you become unwell whilst on Surgery premises.**	
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", please provide us with a copy.**

Do you have any of the following (if yes, please provide us with a copy):

- **Advanced Care Plan**
- **ReSPECT Form**
- **Power of Attorney for Health and Welfare**

Please complete the enclosed 3rd Party Consent Form with your preferences (if applicable).

Women only:			
When was your last smear done?	**Date**	**Was this at your GP Surgery?**	**Yes / No**

What was the result of the smear?	
Date of last mammogram (if applicable):	

IMPORTANT - CONSENT TO SHARE.

The NHS is changing the way your health information is stored and managed.
Please read the separate information provided about the various ways your information may or may not be shared.
It is very important you advise us of your wishes so that we can amend your records accordingly.

Patient Participation Group

The Practice is committed to improving the services we provide to our patients. To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better. By expressing your interest, you will be helping us to plan ways of involving patients that suit you. It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice. If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.

Yes, I am interested in becoming involved in the Practice Patient Participation Group	**Please tick**

Friends of Mann Cottage Surgery

The 'Friends' were founded approximately 18 years ago as a registered Charity and seek to raise funds which go directly towards providing additional facilities and equipment to benefit patients of Mann Cottage Surgery. They are always looking for new members to join this friendly group. If you are interested in knowing more, please speak to a member of our Reception Team.

Patient Signature: or signature on behalf of patient.		**Date:**	

As part of your registration with Mann Cottage Surgery, you will be offered a new patient check appointment with one of our Practice Nurses. Your physical examination will include having your height, weight and blood pressure taken. The Practice Nurse will also help establish relevant past medical and family history, including:

- **Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health**
- **Social factors - employment, housing, family circumstances**
- **Lifestyle factors - diet and exercise, smoking, alcohol and drugs.**

Please keep us up to date with any changes to your circumstances/contact details etc so we can ensure your records are accurate.

Thank you for completing this form

For more information about the services we offer, please refer to the Practice leaflet or see our website: www.moretondoctors.nhs.uk

Revised: November 2019

MANN COTTAGE SURGERY – DR FURN DAVIES & PARTNERS

New patients: Sharing your health care records and information

Your patient record will be held securely and confidentially on our electronic system.

If you require treatment in another NHS healthcare setting such as an Emergency Department or Minor Injury Unit, those treating you would be better able to give you appropriate care if some of the information from the GP practice were available to them. This information can now be shared electronically (with your permission) via:-

1. **SCR - NHS SUMMARY CARE RECORD (used nationally across England)**

2. **GLOUCESTERSHIRE SHARED HEALTH AND SOCIAL CARE INFORMATION (Joining up your information – JUYI - used locally across Gloucestershire).**

3. **ENHANCED DATA SHARING MODEL in SystmOne (EDSM) (used nationally across all healthcare providers using the clinical system called SystmOne).**

In all cases, the information will be used **only by authorised healthcare professionals** directly involved in your care. Your permission will be asked before the information is accessed, unless the clinician is unable to ask you and there is a clinical reason for access.

Please note that these records are **NOT CONNECTED** with the Health and Social Care Information Centre care.data project and will be used ***only*** for the purpose of enabling informed care to be supplied directly to you as an individual.

Parents, guardians or someone with power of attorney can ask for people in their care to be opted out, but ultimately it is the GP's decision whether to share information, or not, because of their duty of care.

If you are caring for someone and feel that they are able to understand, then you should make the information about the different methods of sharing available to them.

Please ask a member of the GP practice staff for details of where to find more information about each of the sharing methods.

Are you happy for us to share this electronic information with clinicians in other NHS organisations (and Gloucestershire County Council social care in the case of JUYI) who are involved in your care? If you would rather we didn't we will put an entry on your record which will prevent your information from being shared.

Please select ONE option in ALL the tables below and complete patient details.

1. Your Choice for SCR	Please tick one box only
I would like my information shared through the Summary Care Record	
I would like a Summary Care Record with additional information added**	
I do not want my information shared through the Summary Care Record	

2.Your Choice for Gloucestershire shared health and social care information (JUYI)	Please tick one box only
I would like my information shared through the Gloucestershire shared health and social care information project	
I do not want my information shared through the Gloucestershire shared health and social care information project	

3.Enhanced Data Sharing Model (SystmOne) Sharing Out	Please tick one box only
I would like my information shared out to SystmOne healthcare providers	
I do not want my information shared out to SystmOne healthcare providers.	

4.Enhanced Data Sharing Model (SystmOne) Sharing In	Please tick one box only
I want my GP practice to view data that is recorded at another SystmOne NHS organisation that may care for me.	
I do not want my GP practice to view data that is recorded at another SystmOne NHS organisation that may care for me.	

Patient details (please complete in CAPITAL LETTERS)			
Title:		**Forenames**:	
Surname/Family name:			
Address:			
Phone No.(s)			
Date of birth:		**NHS number (if known)**	
PATIENT TO PLEASE SIGN BELOW. *If the person signing below is not the patient, please also enter the signatory's name and relationship to the patient, e.g.* **PARENT, GUARDIAN, ATTORNEY**			
Full name:		**Status:**	
Signature:		**Date:-**	

MANN COTTAGE SURGERY
How we use your information

- We collect and hold data about you for the purpose of providing safe and effective healthcare

- Your information may be shared with our partner organisations to audit services and help provide you with better care

- Information sharing is subject to strict agreements on how it is used

- We will only share your information outside of our partner organisations with your consent*

- If you are happy with how we use your information you do not need to do anything

- If you do not want your information to be used for any purpose beyond providing your care please let us know so we can code your record appropriately

- You can object to sharing information with other health care providers but if this limits your treatment options we will tell you

- Our guiding principle is that we are holding your information in the strictest confidence

- For more information about who are our partner organisations and how your data is used please see the privacy notice on our website or please ask a Receptionist for full details.

*Unless the health & safety of others is at risk, the law requires it or it is required to carry out a statutory function