WELCOME PACK – BILTON MEDICAL CENTRE

PAPERWORK REQUIRED FOR REGISTRATION

To assist with your registration please provided us with the following documentation.

1. **NHS Card** (Number can be requested from your previous GP)
2. Completion of the Registration form (Included in this pack)
3. Proof of Identity – This can be any one of the following
    - Passport
    - ID Card
    - Photo Driver's Licence (UK Only)
    - Marriage Certificate (not acceptable on its own)
4. Proof of Address - 1 document confirming your address such as Utility Bill(Gas, Electricity, TV, Telephone) dated within the last 3 months.
   Your address must be within our designated Practice Area. Please note that we cannot accept utility bills in Company names only**. The patient must be named on all documents provided.**

5. New Patient Health Questionnaire (included in this pack)

CHILDREN

- The red baby book or other vaccination record is required for children.
- Children must be registered with a parent or guardian at the same address

VISITORS FROM OVERSEAS

- To register as a patient the NHS requires overseas nationals who have entered the country to show proof of intended residency for a three month period or longer.
- Refugees or asylum seekers will have home office documentation.
- Passport with a valid visa for six months or longer.
- Patient from overseas can be registered as a TEMPORARY RESIDENT if they have an intention to be in the area for 24 hours- 3 month period.

If you have any queries please speak to the reception staff at Bilton Medical Centre.

Today's Date:

_____

BILTON MEDICAL CENTRE
New Patient Registration and Health check Form

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

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

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

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

<table>
<tr><td colspan="5">Full Name:</td><td>Telephone Number:</td></tr>
<tr><td colspan="5">Mr / Mrs / Miss / Ms / Other……..</td><td>Work Number</td></tr>
<tr><td colspan="5" rowspan="4">Address and Postcode</td><td>Mobile Number:</td></tr>
<tr><td>E-mail Address:</td></tr>
<tr><td>Next of Kin:</td></tr>
<tr><td>Next of Kin Contact Number:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td colspan="3">Previous / Mother's surname if different:</td><td>Town & Country of Birth</td></tr>
<tr><td>Marital Status:</td><td></td><td>Gender:</td><td>Male:</td><td>Female:</td><td rowspan="3">Other residents of your home:</td></tr>
<tr><td colspan="5">Occupation:</td></tr>
<tr><td colspan="5">Names & Ages of Children</td></tr>
<tr><td>Housing (Select one)</td><td>House</td><td>Maisonette</td><td>Flat</td><td>Mobile Home</td><td>NHS Number (If Known)</td></tr>
<tr><td colspan="5">Previous Address</td><td>Previous Postcode:</td></tr>
</table>

Previous Doctor Name & Address: **Previous Doctor Telephone No.**					**Previous clinical data released?**	**Yes**	**No**
					If applicable, date you first came to live in Britain: **If previous left country date of leaving:**		
If returning from Armed Forces:		**Your Service or Personnel Number**			**Your Enlistment Date**		
Your Religion:	**C of E**	**Catholic**	**Other Christian (state)**		**Buddhist**	**Hindu**	**Muslim**
	Sikh	**Jewish**	**Jehovah's Witness**		**No religion**	**Other religion (state)**	

Your Ethnic Origin: (select one)	**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: (select one)		**English**	**Hindi**	**Gujurati**	**Urdu**	**Bengali /Sytheti**	**Punjabi**
Polish	**Ukrainian**	**French**	**German**	**Spanish**	**Other: (Please Specify)**		

Smoking, Alcohol Consumption and Exercise:

Are you currently a smoker?	**Yes**	**No**	**Have you ever been a smoker?**	**Yes**	**No**
If so, how many cigarettes / cigars / tobacco do you smoke in a week?			**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. times per week**		**Type(s) of exercise:**		

SMS CONSENT : Y / N (Please circle your choice)

<table>
<tr><th colspan="6">Your Medical Background:</th></tr>
<tr><td>What illnesses have you had & When?

Are you under a consultant at the minute?</td><td colspan="5"></td></tr>
<tr><td>What operations have you had and When?</td><td colspan="5"></td></tr>
<tr><td>Do you have any medical problems at present? i.e dry skin, eczema, Asthma etc</td><td colspan="5"></td></tr>
<tr><td>Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)</td><td colspan="5"></td></tr>
<tr><td>Are you able to administer your own medicines?</td><td>Yes</td><td colspan="4">No – please detail specific issues (e.g. swallowing, opening containers)</td></tr>
<tr><td rowspan="3">Any Family History of (tick all that apply)</td><td>Diabetes</td><td>Heart Attack</td><td>Heart attack under age of 60</td><td colspan="2">Bowel Cancer</td></tr>
<tr><td colspan="2">Breast Cancer</td><td>High Blood Pressure</td><td>Asthma</td><td>Stroke</td></tr>
<tr><td colspan="2">Thyroid Disorder</td><td colspan="3">Any other important Family Illness?</td></tr>
</table>

Measurements						
Blood pressure			**Systolic**	**Diastolic**	**Pulse**	
Height						
Weight						
Immunisations & Vaccinations	**Diphtheria**	**Measles**	**Pneumococcal**	**Tetanus**	**Polio**	**MMR**
Please tick and provide evidence of	**Whooping Cough**	**Pre-school booster**	**Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses**	**Flu Vacc**	**German Measles**	**HPV (given at school)**

WOMEN ONLY:				
When was your last smear done?	**Date**	**Was this at your GP's Surgery?**	**Yes**	**NO**
What was the result of the smear?				
Date of last mammogram (if applicable):	**Date**	**Method of contraception (if used)**		
Are you currently pregnant		**If yes date of last period**		
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?			**Yes**	**NO**

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?		
Please state any Physical disabilities you have:		
Please state any Mental disabilities you have:		
Please state any requirements you have to be able to access the Practice premises		
Please state any Religious or Cultural needs:		
Do you require the help of a Translator / Interpreter?		
Please state any specific nutritional requirements you have:		
Please state any allergies and sensitivities you have:		
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 New Patient Consultation***
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)? By signing, you are agreeing to provide evidence of this.	**Yes / No**	**If "Yes", please state their name / address / phone number:** **Signed by**_____

Summary Care Records. **The NHS are 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. An information pack has been provided.**			
Are you happy to have a Summary Care Record?	**Yes**	**No**	**More Time Required to decide:**

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 the "Yes" Box)	**Yes**

Patient Signature:		**Signature on behalf of Patient:**	
Date		**Date**	

Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).
The Consultation will also 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 drug abuse.***
- ***Safeguarding issues – including any history with social services, involvement with police, MARAC***
- ***Any other issues that you care to share with us.***

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or see our website: biltonmedicalcentre.co.uk

THIS PRACTICE OPERATES A ZERO TOLERANCE POLICY.

VIOLENT OR AGGRESSIVE BEHAVIOR WILL RESULT IN REMOVAL FROM THE PRACTICE.

PATIENT CHARTER

HELP US TO HELP YOU.

The doctors and staff will always do their best for you. We do, however, need your help to provide you with the best care. Please support us with these simple guidelines:

1) Please treat your doctors and their staff as you would expect to be treated by them – with politeness and respect.

2) Please cancel appointments you cannot attend or no longer need – somebody else is always waiting.

3) Please think twice before calling a doctor to your home – is a visit always necessary?

4) Please do not expect a prescription every time you visit the doctor – good advice is often the best medicine.

5) Please request your repeat prescriptions in good time – this will help avoid delays.

6) You can find basic health information elsewhere – for example your pharmacist or NHS Direct.

7) Please remember that doctors are only human – they cannot cure all your problems and illnesses.

8) If you do have a genuine complaint, please contact the Practice Manager first.

Thank you for helping your surgery provide a better service.

Please sign and date this document to confirm you fully understand the patient Charter.

Signed:……. **Date:**……..

Name …… **Date of Birth**…….