**Phoenix Family Care**

**New Patient Registration Form**

 **Today’s Date:**

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice). The information will help us to provide better and more comprehensive care for you. When you register you will be allocated a named accountable GP, although this will not restrict which GP you can see.

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

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| --- | --- |
|  **Surname:** | **Mr / Mrs / Miss / Ms / Other……..** |
| **Forenames:** |  **Telephone Number:** |
| **Address and Postcode:** |  **Mobile Number:****(you may receive appointment and health check reminders by text)** |
|  **Email address:** |
| **Previous UK Address:** | **Previous GP Surgery:** |
| **Date of Birth:** | **Previous surname if****different:** | **Town & Country of Birth:** |
| **Marital****Status:** |  | **Gender:** | **Male:** | **Female:** | **NHS Number (If Known):** |
| **If applicable, date you first came to live in Britain:** |  |
| **If returning from****Armed Forces:** | **Your Service or Personnel Number:** | **Your Enlistment Date:** |
|  |
| **If 16 or over please supply the following information** | **Height** | **Weight** | **Blood Pressure** |
|  |  | **NB: We have a blood pressure self-monitoring machine in reception** |
| **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 day?** |  | *If you are a smoker and want to stop, please ask for information about local smoking cessation services.* |  |
| **1 unit of alcohol = Half a pint of beer, lager & cider or one pub measure of spirits & sherry or a small glass of wine** |
| **Alcohol consumption units per week** |  | **Type** |  |
| **How often do you exercise?** | **No. times per week** | **Type(s) of exercise:** |  |

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| **Your Ethnic Origin:****(select one)** | **White (UK)** | **Mixed White (UK)** | **White (Other)** |
| **Caribbean** | **African** | **Asian** | **Chinese** |
| **Indian/British Indian** | **Pakistani/British Pakistani** | **Bangladeshi/British****Bangladeshi** | **Other Black Background** |
|  **Other Mixed** **Background** | **Other** | **Ethnic Category not stated** |

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| **Your main or First language****Spoken / Understood:**  **Please specify:****P** |  |
| **Do you require an Interpreter:** |  |
|  |
| **Your Medical Background:** |
| **Have you ever suffered from any of the following?** |
| **Condition** | **Yes** | **No** | **Approximate date started** |
| **EPILEPSY** |  |  |  |
| **BLINDNESS/GLAUCOMA** |  |  |  |
| **BLOOD PRESSURE** |  |  |  |
| **DIABETES** |  |  |  |
| **STROKE/TIA** |  |  |  |
| **HEART ATTACK** |  |  |  |
| **ASTHMA** |  |  |  |
| **ECZEMA** |  |  |  |
| **CANCER (BREAST/****BOWEL/LUNG/OTHER)** |  |  |  |
| **ALLERGIC TO PENICILLIN** |  |  |  |
| **OTHER ALLERGIES (if Yes please specify)** |  |  |  |
| **If you are taking any regular medicines please supply a list from your current doctor****NB: You will need to see a doctor here before they can be issued** | **Are you able to administer your own medicines?** |  **Yes/No** | **If ‘No’ please detail specific issues:** |

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| **Are there any serious diseases that affect your Family. Please specify who is affected.** | **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?** |
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| **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):** |  |

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| **For children under 14****Please give dates of all immunisations and bring in their immunisations record book** | **Diptheria, Tetanus, Pertussis, Polio & Hib.****Men B.****1st Dose at 8 Weeks** | **Diptheria, Tetanus, Pertussis, Polio & Hib.****2nd Dose at 12 Weeks**  | **Diptheria, Tetanus, Pertussis, Polio & Hib.****Men B.****3rd Dose at 16 Weeks**  |
| **Hib & Men C Booster.****MMR. Pneumococcal Booster.****Men B Booster.****1 Year Old** | **Diptheria, Tetanus, Pertussis & Polio.****MMR****Pre School 3Years 4Months**  | **Influenza** |

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| **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):** |  |
| **Do you have any communication or****information needs relating to a disability or sensory loss?** |  | **If yes, please specify your need** |  |
| **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:** |  |
| **Please state any specific nutritional requirements you have:** |  |

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| **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”,******Please can you bring in a copy to be held on your medical records*** |
| **Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?** | **Yes / No** | **If “Yes”, please state their name / address / phone number:** |

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| **Care.data Opt-Out** |
| **I do/I do NOT** want my personal confidential data to be released by my GP surgery for the care.data programme. |
| **I do/I do NOT** want my personal confidential data from hospitals and other care providers to be released by The Health & Social care Information Centre (HSCIC) for the care.data programme |

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| **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** |  |

**Email Address:**

**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 fil out your email address or speak to one of our receptionists.**

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

**Please tick the Box**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient****Signature:** |  | **Signature on behalf of Patient:** |  |

**If you are taking regular medicines or have an ongoing medical condition, please make an appointment to see a doctor before you require a repeat prescription.**

**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:*** [***www.phoenixfamilycare.nhs.uk***](http://www.phoenixfamilycare.nhs.uk)

This is one unit of alcohol…



…and each of these is more than one unit



AUDIT – C

|  |  |  |
| --- | --- | --- |
| Questions | Scoring system | Your score |
| 0 | 1 | 2 | 3 | 4 |
| How often do you have a drink containing alcohol? | Never | Monthlyor less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week |  |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 -2 | 3 - 4 | 5 - 6 | 7 - 9 | 10+ |  |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

Scoring:

**SCORE**

A total of 5+ indicates increasing or higher risk drinking.

An overall total score of 5 or above is AUDIT-C positive.

Name:

Address:

**PHOENIX FAMILY CARE**

35 Park Road

Coventry

CV1 2LE

Tel: 02476 227234

http://www.phoenixfamilycare.nhs.uk/

Dear Patient

**New service for patients**

You may be aware that all practices are required to provide all their patients with a named GP who will have overall responsibility for the care and support that our surgery provides to them.

Your named GP will be ………………………………..

Dr …………………… will have overall responsibility for the care and support that our surgery provides to you. **This does not prevent you from seeing any GP in the practice.**

You do not need to take any further action, but if you have any questions, or wish to discuss this further with us, please contact us on 02476 227234

Kind Regards

Dr Exton