Thank you for applying to join Ar Razi Medical Centre. As a new patient to the practice we would like to ask you to complete the following questionnaire. This will assist in providing you with the best care. You must sign the form on the final page to confirm all the details given are correct.

All information given to us will be confidential and used only in accordance with statutory regulations, e.g. Data Protection Act/GPDR.

UK residents and those residing in the UK for legal and settled purpose, AND living within the practice area, are entitled to register with us. We reserve the right to remove patients who do not live within our practice boundary. If you register with the practice and are not living in the area this will affect the services that we can provide for you, for example no home visits will be undertaken outside of practice boundaries. All patients found not to be living in the practice area will be removed from our list with 28 days notice. UK citizens who now live abroad for most of the year may not entitled to free NHS care. European Economic Area (EEA) rules apply for those residing in a member state.

Please complete all areas that are applicable to you or your child in **CAPITAL LETTERS** and tick the appropriate boxes.

Full Name			Date of Birth
Mobile Telephone Number			Email Address
Single Cohabiting Widowed Married Divorced Separated Civil partnership			Occupation

*What is your ethnic group? (please circle the option that best describe your ethnic							
White		English/Welsh/Scottish		Northern Irish		Irish
BlacK		Caribbean		African		Other
Asian		Indian		Pakistani		Chinese
Mixed		White + Black Caribbean		White + African		White + Asian
Other *Please spec-*						

*Main spoken languages	
English	
Other (please specify)	
Interpreter required?	
Yes	No

Next of kin

Name of next of kin		Relationship to you/child

Are you a Military Veteran?

Yes No

Do you have a Carer? Yes No

If yes, what is their name and contact number?

Are you a Carer? Yes No

If yes, do you look after someone who is a patient of here at Ar Razi Medical Centre Yes No

If yes, what is their name?

What is your relationship to them?

If No, please give the address of the surgery or the name of the GP who treats the person you care for:

We will refer you to the Carers Service for further information and support. Please tick if you do **NOT** wish to be referred ☐

Carers provides information and advice and free services such as gym sessions, sitting service, holidays and emotional support.

If Registering a Child please complete the following:

If you are applying on behalf of a child who is in foster care/residential care/Kinship care/ or who is not your child:

Who has the parental or legal responsibility for the child?

You as the legal parent/guardian/adoptive parent

Other (please specify)

Name:

Contact Number:

Evidence of parental responsibility (birth certificate/social care information) :

If you are the parent/guardian/foster carer /kinship carer **but cannot** consent please detail below who can

Name:

Relationship to child:___________________________________

Contact Number:

If a child, are they looked after? Yes No

If Yes, under what arrangements:

Section 20-Voluntary Care Subject to an Interim Care Order Subject to a Full Care Order

Placed for adoption Unaccompanied Asylum Seeker

Private arrangement/Private Fostering/informal arrangement

(please note you have a duty to notify social care of this arrangement)

What is Private Fostering?

A private fostering arrangement is one that is made without the involvement of the Local Authority to look after a child under the age of 16 (or under 18 if disabled) by someone other than a parent or close relative, for 28 days or more and can include those living with extended family members. So, this could be a child living with people as stated below:

*Private Fostering **includes** a child living with:*	*Private Fostering **does not include** a child living with:*
godparents	brothers
great-grandparents	sisters
great aunts or uncles	grandparents
family friends	aunts
step parents where a couple isn't married or in a civil partnership	uncles
cousins	step parents where a couple is married or in a civil partnership
a host family which is caring for a child from overseas while they	mother

Name of school or nursery:	Home schooled.
Does the child have a social worker? **Yes No**	Name of Social Worker:
Are there any other Agencies involved in their care? **Yes No. Contact Details:**	

Medical details

Please provide information below if known

Height	m	cm
Weight	kg	

If over 18 please provide recent BP reading.

This can be taken on one of the practice machines

BP reading :

If BP > 140/90 please arrange 5 day BP reading at reception

For women aged 25 to 64) Have you had a cervical smear test?	
Yes	No
If Yes Please state where, when and the result(if known)	

Do you have any current health problems, please include dates? (Asthma, COPD, Diabetes, Heart Disease, Learning disabilities, mental health problems)

If you have any of the above please make an annual review appointment.

Are you taking any medication? Yes No

Please provide repeat prescription or list of medication from previous practice.

If you are a patient on repeat medication please make a medication review appointment.

Are you allergic to any medicine or other substance? NO	YES - please list below

Family History			
Only tick if these apply to first degree relatives. i.e parents and siblings.	Asthma	Diabetes	Heart disease
	High Blood Pressure	Stroke/Mini Stroke	Skin conditions
	Depression	Peptic ulceration	Thyroid Disorder
	Eyesight problems	Asthma/COPD	Cancer

* What are your smoking habits? Smoker Ex-Smoker Never Smoked

How many do you smoke a day? ____________

Would you like advice on quitting?

Yes No

Lifestyle:

How would you describe your diet? What are your exercise habits?

Good diet	Exercise impossible	
Average diet	Light exercise	In what form:
Poor diet	Moderate exercise	In what form:
Vegetarian / Vegan	Heavy exercise	In what form:

mmunisations

If you are from abroad please give a copy of your immunisations.

If a child - are they up to date with their immunisations? Yes No (if no please specify)

Domestic Abuse: If domestic abuse is affecting your health you can speak to someone here.

Please tick this box if you would like a GP to contact you.

On-line services

If there are any problems with your registration we will contact you to clarify any issues, but once your details have been entered into our computerised records you will be able to register with our **on-line service** provider (System One) and access appointments, prescriptions and some sections of your own me

Scan to Patient

Application for online access to my medical record

I wish to access my medical record online and understand and agree with each statement (please tick)

1. I have read and understood the information leaflet provided by the practice	
2. I will be responsible for the security of the information that I see or download	
3. If I choose to share my information with anyone else, this is at my own risk	
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without	
5. If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the	

On-line account

Text reminders for appointments

Would you like to receive text reminders for appointments?	Yes No
I consent to the practice contacting me by text message and/or e-mail for the purposes of health promotion, practice news and appointment reminders. I acknowledge that the appointment reminders by text are an additional service and that they may not be sent on all occasions and the responsibility for attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time. Text messages are generated using a secure facility but I understand that they are transmitted over a public network onto a personal telephone and as such may not be sure, however, the practice will not transmit any information which would enable an individual patient to be identified. **I agree to advise the practice if my mobile number changes or if it is no longer in my possession.**	

Data Sharing

Summary Care Record (SCR)

The SCR is a summary of your medical history that can be shared between healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. **More information can be found by visiting www.nhscarerecords.nhs.uk and *practice website***

Tick this box if you wish to opt-in to the SCR

Tick this box if you wish to opt-out of the SCR

Please collect an opt out form reception or download a form from ***practice website***

National Data Opt-out
Due to the introduction of the General Data Protection Regulation (GDPR) in May 2018 there have been national changes on how patients record their preference as to how they would like their data shared.

More information can be found by visiting the NHS website https://www.nhs.uk/your-nhs-data-matters/ . You can update your preferences there.

Electronic Prescription Service (EPS)

All prescriptions will now be sent electronically.

Please nominate a pharmacy:

(So we can send your prescription direct to them)

***Signed**		***Date** (dd/mm/yyyy) / /

Signed on behalf of patient (*if applicable*) (Minors under 16 years old, adults lacking capacity)	**Full Name:**
	Relationship:

Thank you for providing this information. We look forward to providing you with a high standard of care in a friendly and professional manner.