**NEW PATIENT REGISTRATION**

Please complete this form as clearly as possible and return to us along with a form of ID (passport or driving licence, utility bill/bank statement etc.)

Where you are providing information and ticking consent boxes, you are agreeing to The Orchard Partnership contacting you by text message, email or voicemail for the purpose of appointment reminders, results, action needed following test results, referrals, health promotions, non-NHS work, medication and Partnership updates.

Please be aware that the responsibility for attending appointments and cancelling them, as well as contacting the Partnership to obtain the results of recent tests, still rests with the patient.

**Consent to receive communication**

Icon

Description automatically generatedEmail Icon Png, Transparent Png - kindpngBy Email 🞏 Yes 🞏 No By Text 🞏 Yes 🞏 No By Voicemail 🞏 Yes 🞏 No

**My preferred communication method is:**

Email Icon Png, Transparent Png - kindpng By Email 🞏 Yes 🞏 No By Text 🞏 Yes 🞏 No  Letter 🞏 Yes 🞏 No

*If you have additional needs, please tell us which way you would prefer us to communicate with you (you may choose multiple)*

*Icon

Description automatically generated*Icon

Description automatically generated With large text 🞏 With a language interpreter 🞏

A blue sign with white text

Description automatically generated with medium confidence

Upon registration, we will automatically set you up for online access where you can view coded results, book appointments and order repeat prescriptions online. Tick here if you wish to OPT OUT 🞏

**ABOUT YOU**

NHS number (if known) ………………………………………………..………. Male 🞏 Female 🞏

Title MR 🞏 MISS 🞏 Ms. 🞏 MRS 🞏 Other ..................... First Name(s) ...........................................................................

Surname ............................................................................. Previous Surname *(if applicable)* .............................................................

Date of Birth ............./............./............. Town & Country of Birth ..................................................................................................

Current Address.....................................................................................................................................................................................

.................................................................................................................................Post Code .............................................................

Previous address in the UK....................................................................................................................................................................

...............................................................................................................................................................................................................



Landline number …………………………………….. 🞏 Preferred Mobile number……………………………………..... 🞏 Preferred

Email Icon Png, Transparent Png - kindpng

Email ........................................................................................................................................................................................

Please indicate your ethnic origin:

🞏 White – British 🞏 White – Irish 🞏 White - Gypsy or Irish Traveller 🞏 White – Other 🞏 African 🞏 Caribbean 🞏 Indian 🞏 Pakistani 🞏 Bangladeshi

🞏 Chinese 🞏 Black or Black British -Other 🞏 Arabian 🞏 White and Asian

🞏 White and Black African 🞏 White and Black Caribbean 🞏Mixed – Other 🞏 Other 🞏 Decline to state

**Please list any allergies you have to any drugs / medication**

**Name of medication What was the problem or upset**

**NEXT OF KIN** (these details will be held on file)



Their name ..................................................... Relationship to you ..................................... ..............................................

**If you need your GP to dispense prescriptions:**

🞏 Tick here if you live more than 1 mile in a straight line from the nearest pharmacy and we will dispense your medication at the surgery. Otherwise please tell us where you would like to collect your medication from.

Name of pharmacy ................................................................................. Town …............................................................................

**IF YOU ARE FROM ABROAD** which country have you come from? …………………………………………………………………………………………………

Your first UK address where registered with a GP ................................................................................................................................

…………………………………………………………………… Date you first came to the UK or left the UK ................................................................

**IF YOU ARE RETURNING FROM THE ARMED FORCES**

Address before enlisting .......................................................................................................................................................................

...............................................................................................................................................Post Code ..............................................

Enlistment date….............................................................. Date of leaving service ............................................................................

Service/Personnel Number ....................................................... Are you a military veteran? YES 🞏 NO 🞏

Is your husband/wife/partner serving in the Armed Forces or a War Veteran? YES 🞏 NO 🞏

**HEALTH RECORD CONSENT**

Do you consent to your GP Practice viewing your health record from other services that care for you?

Yes 🞏 (recommended) No, never 🞏

Do you consent to your GP health record being made available to other NHS care services that care for you?

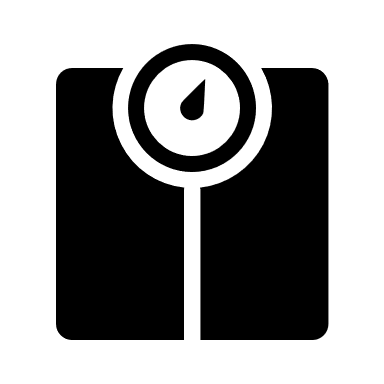
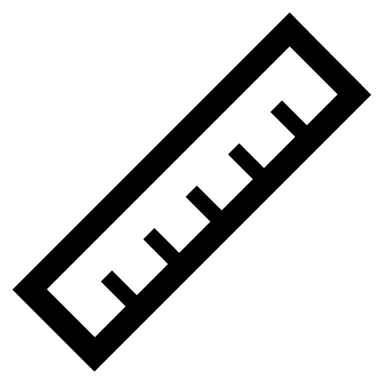
Yes 🞏 (recommended) No, never 🞏

**CARER INFORMATION**

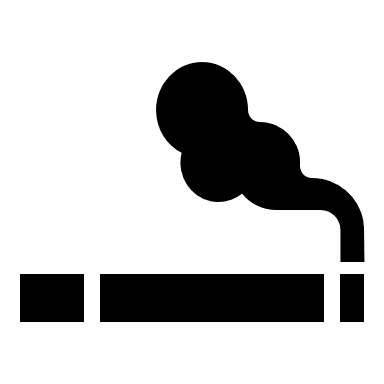
Are you a carer? YES 🞏 NO 🞏 *If yes, do you consent to this information being held on our Carer’s Register?* YES 🞏 NO 🞏

Do you have a carer?YES 🞏 NO 🞏 *If yes, please give their name & contact number* .................................................................

Their address ........................................................................................................................................................................................



**LIFESTYLE** Height .................................................. Weight .......................................................

 **Do you smoke**? 🞏 YES 🞏 NO

🞏 Ex-Smoker? 🞏 Never Smoked

If yes, do you smoke:

Cigarettes 🞏 Cigars 🞏 Pipe 🞏   
How many per day? 🞏 1/day 🞏 1-9/day 🞏 10-19/day 🞏 20-39/day 🞏 40+/day

If you smoke a pipe, how many ounces of tobacco per week? ...............................

Would you like help to **Quit Smoking**?   
 🞏 YES 🞏 NO

**FAMILY HISTORY**

**Do you drink alcohol**? 🞏 YES 🞏 NO

*If yes, please answer the following questions:*

How often do you have a drink that contains alcohol?

🞏 Never 🞏 Monthly or less 🞏 2-4 times/month

🞏 2-3 times/week 🞏 4+ times/week

How many standard alcoholic drinks do you have on a typical day when you are drinking?

🞏 1-2 🞏 3-4 🞏 5-6 🞏 7-8 🞏 10+

How often do you have 6 or more standard alcoholic drinks on one occasion?

🞏 Never 🞏 Less than monthly 🞏 Monthly 🞏 Weekly

🞏 Daily/almost daily

Please indicate in the boxes if any close relatives (father, mother, sister, brother only) have ever suffered from the following: -

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| HEART ATTACK | STROKE | DIABETES | HIGH BLOOD PRESSURE | ASTHMA | GLAUCOMA | CANCER |
|  |  |  |  |  |  |  |

**SUMMARY CARE RECORD** [**https://digital.nhs.uk/services/summary-care-records-scr**](https://digital.nhs.uk/services/summary-care-records-scr)

Having read the above information in the above link regarding your choices, please choose one of the options below:

🞏 Express consent for medication, allergies, adverse reactions and additional information (**recommended**)

🞏 Express consent for medication, allergies and adverse reactions only.

🞏 Express dissent for Summary Care Record (OPT OUT)

Patient signature: .............................................................................. Date: ...................................................