JUNCTION MEDICAL PRACTICE

Main: 244 Tufnell Park Road, London, N19 5EW
Branch: 18 Dartmouth Park Hill, London, NW5 1HL
Phone: 02072729105 Email: junction.medicalpractice@nhs.net

New Patient Registration

About you

Surname: …… Forename(s): ……

Date of Birth (dd/mm/yyyy): ……..

Gender: ……

Contact Information

Telephone: …… Mobile: ……

Email: ……

Please circle below your preferred choice of contact:

Text Phone Email Post

Do you live in a residential/nursing home? **Yes** ☐ **No** ☐

What is your occupation?.....

Service Families and Military Veterans

As a practice, we fully support the Armed Forces Covenant. We can only do this if we know our patients connections to the Armed Forces. Please tick the below boxes that apply to you:

I AM a Military Veteran		**I AM** currently serving in the Reserve Forces	
I AM married/civil partnership to a serving member of the Regular/Reserve Armed Forces		**I AM** married/civil partnership to a Military Veteran	
I AM under 18 and my parent(s) are serving member(s) of the armed forces.		**I AM** under 18 and my parent(s) are veteran(s) of the armed forces.	

Ethnicity

Having information about patients' ethnic groups would be helpful for the NHS so that it can plan and provide culturally appropriate and better services to meet patients' needs.
If you do not wish to provide this information you do not have to do so.
Please indicate your ethnic origin by ticking the below box:

British or mixed British		Pakistani	
Irish		Bangladeshi	
African		Chinese	
Caribbean		Other (Please state)	
Indian			

Country of birth

In which country were you born?.....

Main language

Which is your main language?.....

Do you need interpreter? **Yes** ☐ **No** ☐

If **yes**, what language……..

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Carer status

Do you have a carer? **Yes** ☐ **No** ☐

If Yes, please give details of their name, relationship and whether they are a patient here too……..

Are you yourself a carer? **Yes** ☐ **No** ☐

Next of kin

Surname: …… Forename(s): ……

Relationship: ……

Emergency contact Information (for next of kin)

Telephone: …… Mobile: ……

Smoking status

Do you smoke? **Yes** ☐ **No** ☐

If yes, how many cigarettes do you smoke daily: ……

If no, have you smoked in the past? **Yes** ☐ **No** ☐

How many cigarettes did you smoke daily?

If you would like help and advice on how to give up smoking, please ask at reception.

Alcohol intake

How much alcohol do you drink in a week?.....

If you would like help and advice on how to reduce your alcohol intake, please contact https://www.drinkaware.co.uk/ or ask at reception.

Height/Weight

What is your height: ……

What is your weight:……..

If you would like advice on managing a healthy weight, please contact https://www.nhs.uk/live-well/ or reception who will be able to direct you to the most appropriate service.

Disabilities / Accessible Information Standards

As a practice we want to make sure that we give you information that is clear to you. For that reason we would like to know if you have any communication needs.

Do you have any special communication needs?

Yes ☐ **No** ☐

If yes, please state your needs below:……

Do you have significant mobility issues? **Yes** ☐ **No** ☐

If yes, are you housebound? **Yes** ☐ **No** ☐

(Definition of housebound - A patient is unable to leave their home due to physical or psychological illness)

Are you blind/partially sighted? **Yes** ☐ **No** ☐

Do you have significant problems with your hearing? **Yes** ☐ **No** ☐

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Family History and past medical history

Have any close relatives (parent, sibling or child only) ever suffered from any of the following?

Condition	Yes	No
Heart Disease (Heart attack/Angina)		
Stroke		
Diabetes		
Asthma		
Cancer		

Have you yourself ever suffered from any important medical illness, operation or admission to hospital? **If so** please enter details below:

Condition	**Year diagnosed**	**Ongoing?**

Allergies

Please list any drug or food allergies that you have:
……
……
……

Medications

Please provide a list of repeat medications:
……
……
……

For female patients only

Have you had a cervical smear test? **Yes** ☐ **No** ☐

If yes, when was this last done? (dd/mm/yy)

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Contacting you – GDPR Patient Consent Form

We will use your contact details to send reminders about appointments, reviews and other services which may be of benefit in your medical care. By completing this form you consent to your being contacted by the Practice by the methods shown below. If you wish to withdraw your consent at any point, please contact the Practice in Writing.

Do you consent to the Surgery sending letters to your home address? **Yes** ☐ **No** ☐

Do you consent to the Surgery sending text messages to your mobile? **Yes** ☐ **No** ☐

Do you consent to the Surgery sending messages to you by email? **Yes** ☐ **No** ☐

Do you consent to the Surgery leaving messages on your phone? **Yes** ☐ **No** ☐

(We will not leave detailed messages on your phone, but may ask you to contact us or leave a simple message if we do not need to speak to you).

Summary Care Record

Summary Care Record (SCR)
If you decide to have a SCR, it will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had it will also include basic information about your current diagnoses. Giving healthcare staff access to this information can prevent mistakes being made when caring for you in an emergency or when your GP practice is closed. Your Summary Care Record will also include your name, address, date of birth and your unique NHS Number to help identify you correctly. If you and your GP decide to include more information it can be added, but only with your express permission.

Summary Care Record Options	**Please Tick**
YES I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had	
YES I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had **AND** any other information that I have agreed with my GP Practice to have included in my Summary Care Records *Please indicate what information you would like adding if you know*	

For more information: Phone 0300 123 3020 or visit www.nhscarerecords.nhs.uk

I do not wish to have a Summary care Record (N.B. this will mean NHS Healthcare staff caring for you may not be aware of your current medications, any allergies or reactions to previous medication.) **I wish to opt out of SCR** ☐

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Electronic Prescribing Service (EPS)

The EPS allows prescribers – such as GPs and practice nurses to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. The NHS aim that by 2020 they will hopefully be paper free or a paper-lite service. To help achieve this The As a practice, we would encourage all patients to opt for electronic prescribing.

☐ **I DO** give consent for my prescriptions to be sent electronically to the pharmacy

☐ **I DO NOT** give consent for my prescriptions to be sent electronically to the pharmacy

Nominated pharmacy……
Address…….
Postcode……

Application for online access to my medical record

Surname	Date of birth
First name	
Address Postcode	
Email address	
Telephone number	Mobile number

I wish to have access to the following online services (please tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record for (level of detail requested)	
• Allergies	☐
• Medication	☐
• Laboratory test results	☐
• Documents	☐
• Immunisations	☐
• Problems	☐
• Consultations	☐

I wish to access my medical record online and understand and agree with each statement (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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible	☐
6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible.	☐

Signature	Date

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For practice use only

<table>
<tr><td colspan="2">Patient NHS number</td><td colspan="2">Practice computer ID number</td></tr>
<tr><td>Identity verified by (initials)</td><td>Date</td><td colspan="2">Method
Vouching ☐
Vouching with information in record ☐
Photo ID and proof of residence ☐</td></tr>
<tr><td colspan="3">Authorised by</td><td>Date</td></tr>
<tr><td colspan="4">Date account created</td></tr>
<tr><td colspan="4">Date passphrase sent</td></tr>
<tr><td colspan="2">Level of record access enabled
All ☐
Prospective ☐
Retrospective ☐
Detailed coded record ☐
Limited parts ☐</td><td colspan="2">Notes / explanation</td></tr>
</table>