



New Patient Registration Form

Welcome to Worthing Medical Group. We are pleased that you have chosen us as your medical practice. This form is very important – it helps us collect the information we need to register your new details with the NHS and organise any further tests or investigations that might be needed. All your information is kept strictly confidential within the NHS and not shared or used without your consent.

PLEASE COMPLETE ALL DETAILS AS FULLY AS POSSIBLE: Areas marked * are mandatory

Return to reception or by e-mail to worthingmedicalgroup@nhs.net

BASIC DETAILS

Title * e.g Mr, Mrs, Miss etc.		Occupation *	
Surname *			
Previous Surname			
Forenames *			
Preferred name (if different to above)			
Date of Birth *		Place of birth *	
Your current home address including postcode *			
Home phone number			
Mobile phone number			
We send automatic text message reminders the day before your appointments with us and you can cancel your appointments by text as well. To OPT OUT of this free service tick this box <input type="checkbox"/>			
E-mail address			
We only send out general information by email such as newsletters. For security reasons we do not send out any confidential information. We will email you very occasional newsletters etc. We also have a participation group that we ask for feedback and to help us improve the surgery. To JOIN tick this box <input type="checkbox"/>			
Patient Access is an internet service through our website that lets you book and cancel appointments on-line and also order your repeat medicines for collection /delivery at any local pharmacy. To JOIN tick this box <input type="checkbox"/> You should then complete your Patient Access registration online at www.worthingmedicalgroup.co.uk			

INFORMATION SO WE CAN TRACE YOUR MEDICAL RECORDS

NHS number *	
Your previous address including postcode *	

Previous GP * Name Address	
Have you been registered here before?	<input type="checkbox"/> No <input type="checkbox"/> Yes If so, when?
If you have moved from abroad, date of arrival in the UK	
Next of kin Name Address Phone number Relationship to you (this is useful if you are under 16 or have a carer)	Are they your carer? <input type="checkbox"/>
If ex-armed forces: Address before enlisting Dates of service (from/to)	
Special Circumstances Please tick if any of these apply to you	<input type="checkbox"/> I have a carer <input type="checkbox"/> I am a carer (non-professional) <input type="checkbox"/> Asylum seeker <input type="checkbox"/> Housebound <input type="checkbox"/> Live in a nursing home <input type="checkbox"/> Live in a residential home <input type="checkbox"/> Live in a community psychiatric home <input type="checkbox"/> Live in a children's home

HEALTH AND LIFESTYLE

Smoking Status * Please complete if you are 12 years or older	<input type="checkbox"/> Never Smoked <input type="checkbox"/> Ex-smoker – Date stopped: <input type="checkbox"/> Cigarette Smoker: per day <input type="checkbox"/> Cigar Smoker: per day <input type="checkbox"/> Roll-ups: oz / g Per week <input type="checkbox"/> Pipe: oz / g Per week					
<i>The surgery offers a stop smoking service, run by our nurses. Nicotine replacement or other tablets are available on an NHS prescription with psychological support over 3 months to give you the best possible chance of quitting. Please ask reception for more details.</i>						
Alcohol Use * How many units of alcohol do you drink in a typical week? *	A unit of alcohol is approximately ½ pint standard (3.5%) beer / ⅓ pint of premium (5%) beer / 125 ml of wine / 25ml of spirits.					
Alcohol Use Screening * <i>Please circle your answer to each question</i>	0	1	2	3	4	Your Score
Men: How often do you have EIGHT or more drinks on one occasion? Women: How often do you have SIX or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily	
How often during the last year have you been unable to remember what has happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily	
How often during the last year have you failed to do what was normally expected of you because of drink?	Never	Less than monthly	Monthly	Weekly	Daily	
In the last year has a relative or friend or a doctor or other health worker be concerned about your drinking suggested you should cut down?	No	Yes – on 1 occasion (score 2)		Yes – on more than 1 occasion (score 4)		
Add up your scores: if the total is THREE or more please ask reception for our more detailed questionnaire.						

ABOUT YOUR PAST MEDICAL HISTORY

<p>Do you currently suffer from any medical problems / conditions / illnesses / diseases? *</p> <p>Please give brief details and approximate dates</p>	<p>Date</p>		
<p>Have you had any significant medical problems / diseases / illnesses / operations in the past? *</p> <p>Please give brief details and approximate dates</p>	<p>Date</p>		
<p>Immunisations *</p> <p>Please list any recent immunisations e.g. flu, pneumococcal etc.</p>	<p>Date</p>		
<p>Please list all your current medications *</p> <p>Ensure you include inhalers, dressings and appliances.</p> <p>(or you can attach a copy of your previous surgery's repeat medicines list if you prefer – tick here <input type="checkbox"/>)</p>			<p>Dose / Strength e.g. 20mg tabs</p> <p>Times per day</p>
<p>If you are on repeat medicines you <u>must</u> make an appointment with your new GP. We would really like to review your medicines and make sure all the medicines you take are necessary and correctly prescribed. Please ask the receptionist to organise an appointment for you at a convenient time.</p>			
<p>We will send your prescriptions to your preferred local pharmacy where you can collect your medicines at your convenience (or have them delivered). Which pharmacy would you like to use?</p>			
<p>Do you have any allergies? *</p> <p>Please also tell us the nature of the reaction</p>			

Family History Please tick any of the following that apply to first degree relatives (parents, children, brothers & sisters)	<input type="checkbox"/> Heart attack/ angina (onset before age 60) <input type="checkbox"/> Heart attack/ angina (onset after age 60) <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer: (type) <input type="checkbox"/> Any other inherited condition:	Detail of who is affected
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PHYSICAL DETAILS

Please use the surgery equipment (if you are over 16) to take the best of 2-3 blood pressure readings. The surgery has a free height and weight machine operated by a token, available from reception.

Blood Pressure * (over 16s) Please use the lowest set of values	Systolic	Diastolic	Pulse
Weight * We prefer kg but are happy with st and lb		Height * We prefer cm but are happy with ft and in	
If you would like help with weight reduction, this free service called "Why Weight" is provided by NHS West Sussex and you can contact them on 0300 123 0892 (Mon – Fri 9am – 5pm)			

ETHNICITY AND LANGUAGE

Ethnic Origin * Knowing your ethnic origin is important for some of our tests and may affect which medicines work best for you.	<i>White</i> <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Other
	<i>Asian / Asian British</i> <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Other
	<i>Black / Black British</i> <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Other
	<i>Other/Other British</i> <input type="checkbox"/> Chinese <input type="checkbox"/> Other
First Language	

Where did you hear about Worthing Medical Group?	<input type="checkbox"/> Word of mouth <input type="checkbox"/> NHS Website <input type="checkbox"/> Google / Search Engine <input type="checkbox"/> Local press <input type="checkbox"/> Walked past it <input type="checkbox"/> Practice website <input type="checkbox"/> Other (please state):
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DECLARATION

I declare that I am / my child* is entitled to NHS services because I have been or intend to be ordinarily resident in the UK for a period of 6 months or longer. I am registering with Worthing Medical Group and authorise them to obtain my past medical records from my previous UK GP.

Signature:
(If sending by e-mail write "signed electronically")

Date:

For Surgery Use Only

Form accepted & checked by:

Details of any appointments made:

Smoking cessation advice provided by:

or ☐ N/A

Registered on EMIS as temporary pt by:

Data template completed by:

Patient registered as active on EMIS by: