NEW PATIENT REGISTRATION FORM– ADULT

IDENTIFICATION:

Driving Licence ☐
Passport ☐
Utility Bill ☐
Other ☐

ID CHECKED BY: .....

WESTBOURNE MEDICAL CENTRE

ADMIN USE ONLY:

Form accepted on: (date) .....

Form accepted by: (initials) .....

Entered on SystmOne on: (date) .....

Entered on SystmOne by: (initials) .....

Your Details:

First Name .....

Surname .....

NHS Number .....

Date of Birth .....

Address .....

.....

Postcode .....

Contact Phone Number (Preferred)

Mobile ..... ☐

Home ..... ☐

Work ..... ☐

Email address .....

Ethnicity .....

First Language .....

Place of Birth .....

Height .....

Weight .....

Occupation .....

Have you served in the Armed Forces? .....

Provide Details .....

Next of Kin / Emergency Contact:

Full Name .....

.....

Relation to you .....

Contact Phone Number

Mobile .....

Home .....

Address .....

.....

Postcode .....

Family Members:

Is there anyone registered with us, living at the same address?
If **YES,** please complete below for further details:

Full Name .....

.....

Relation to you .....

Date of Birth .....

Electronic Prescription Service (EPS):

Please nominate a pharmacy for us to send your prescriptions to electronically

.....

.....

Tick NO if you do not wish to use EPS ☐ **NO**

Text Messaging:

I acknowledge that information including appointment reminders sent by text are an additional service, not under the control of the practice and that the practice cannot guarantee that a message will always be sent. I understand that the practice does not respond to replies on its SMS text service. I agree to advise the practice if my mobile number changes.

I consent to being contacted via text message: **YES** ☐ **NO** ☐

Declaration:

In order for you to be registered with this practice you must be 'lawfully living in the UK, voluntarily for a settled purpose' for over 3 months and reside in the practice area.
Please confirm that you fulfil these criteria by signing this form.

Signature:..... **Date:**.....

☐ Signed by patient ☐ Signed on behalf of patient (Relationship to patient .....)

NEW PATIENT REGISTRATION FORM– ADULT

The government has issued a directive to address the problem of illness associated with alcohol consumption.
To help in this initiative we can screen adults over 16 and assess the risk of drinking at hazardous/harmful levels.
This will enable the practice to provide a simple brief intervention where needed.

Please answer the following questions (Alcohol 'FAST' screening test)

How many units of alcohol do you drink per week? …… units/week

1 unit = Single measure of Spirits
2 units = Pint of regular Beer/Larger/Cider
2 units = Glass of Wine (175mil)
9 units = Bottle of Wine = 9 units

Remember, drinks poured at home are usually bigger

Scoring:	0	1	2	3	4	Total:
How often do you have 8 units (Men) or 6 units (Women) or more on one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
If you scored zero above, then FAST is negative and you may stop. If you scored 1-4 then carry on.						
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/doctor/health worker been concerned about your drinking/advised you to cut down?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	

Other information:

Are you a current smoker? YES / NO

If YES, how many per day? ……

Smoke Stop: If you would like advice on how to stop smoking please visit www.livewelldorset.co.uk or phone 0800 840 1628 or 01305233105

If you no longer smoke, when did you stop? ……

Previous GP details

Name ……

Town ……

County ……

Why did you leave your last Practice?

- Moved out of area ☐
- Unhappy with service ☐
- Other (Please specify)…… ☐

Why did you choose Westbourne Medical Centre?

- Good reputation/ recommended ☐
- Closest location/ Convenient ☐
- Tried other local practices but not accepted ☐
- Other (Please specify)…… ☐

Are you a carer or cared for? ……

If you are a carer or are being cared for please speak to Reception for more information about the carers register and support services available to you.

Accessible Information Standard Communication Needs:

Do you have any special communication needs?

YES ☐

NO ☐

If **YES,** further details ……

If **YES,** what is your preferred method of communication?

Letter ☐
Email ☐
Telephone ☐

Braille: Grade 1 ☐
Grade 2 ☐

Written:
Font 12 ☐

Font 20 ☐

Font 28 ☐

Signature:…… **Date:** ……

☐ Signed by patient ☐ Signed on behalf of patient (Relationship to patient ……)