**Rye Medical Centre **

Please complete this form and bring to the surgery when you come to register.

**About You**

|  |  |  |  |
| --- | --- | --- | --- |
| **Forename(s)** |  | **Title (Mr/Mrs/Mx (etc)** |  |
| **Surname** |  | **Date of Birth** |  |
| **Home Tele Number** |  | **Mobile Tele Number** |  |
| **Email address** |  | | |
| **Marital Status** |  | **Occupation** |  |
| **Your first language** |  | **Your ethnic origin** |  |

**Summary Care Record –** Please see information leaflet/Practice Guide for more information

|  |  |
| --- | --- |
| **Do you wish for your clinical information to be added to the NHS Summary Care Record?**  **We will automatically add you to the SCR with additional information unless you specify** | Yes Core details only [ ]  Yes with additional info [ ]  No [ ]  **If your answer is NO, you will need to complete an opt-out form. Please ask the reception for a form.** |

**Communication Consent & Data Sharing –** Please see Privacy information leaflet/Practice Guide for more information. Please also complete the separate communication consent form.

|  |  |
| --- | --- |
| **If you would like to receive information from your Patient Participation Group please tick the box.** | Consent to emails from Patient Participation Group  Yes - [ ] No - [ ] |

**Do you have any Communication Needs or Mobility Issues?**

|  |  |  |
| --- | --- | --- |
| **No – [ ]**  **Tick box & go to next section**  **Yes – [ ]**  **Please give details** | Do you have support? [ ]  (i.e. advocate/note taker/sign language)  Do you need support? [ ]  (i.e. note taker/interpreter) | Do you need specific format?  [ ]  (i.e. large print/braille) |
| **Mobility** | Fully Mobile [ ] Housebound [ ] Mobile with aid [ ] | |

**Next of Kin –** must be spouse or relative

|  |  |  |  |
| --- | --- | --- | --- |
| **Full Name** |  | | |
| **Address** |  | | |
| **Relationship to you** |  | **Contact Number** |  |
| **Does your Next of Kin consent for this information to be added to your medical record?** |  | | |

**Carer Details**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Are you a carer? Do you have a carer? Would you like to be added to the Practices register to receive information and support?** | | | Yes [ ]  No [ ] | |
| **(If yes) I care for/my carer is (name)** | |  | | |
| **Relationship to you** |  | | | |
| **The person I care for has** | Dementia [ ] | Physical Disability [ ] | Mental Illness [ ] | Chronic Disease [ ] |

**Health Questionnaire**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Smoking status** | Never smoked [ ] | | | Ex-Smoker [ ] When did you stop? | | | | Current smoker [ ] How many a day? | | |
| **Alcohol** | If you drink, how much per week? | | | | | | | | | |
| **Diet** | Are you on any special diet? | | | | | | | | | |
| **Do YOU suffer from/have you suffered from any of the following** | | **If yes Date or year** | | | **Do YOU suffer from/have you suffered from any of the following** | | | | **If yes Date or year** | |
| Heart Attack | |  | | | Liver Disease or splenectomy | | | |  | |
| Angina | |  | | | Kidney Disease | | | |  | |
| High Blood Pressure | |  | | | Chronic Lung Disease | | | |  | |
| Coronary Artery Operations | |  | | | Asthma | | | |  | |
| Stroke/CVA/TIA | |  | | | Osteoporosis | | | |  | |
| DVT or pulmonary embolism | |  | | | Thyroid Disease | | | |  | |
| Diabetes | |  | | | Cancer | | | |  | |
| Do you suffer from any other medical condition? | |  | | | Do you have any drug/non-drug allergies? | | | |  | |
| **Has any FAMILY member had/developed** | | | | | | | **If yes – who & age** | | | |
| Heart Disease | | | | | | |  | | | |
| Stroke | | | | | | |  | | | |
| Cancer | | | | | | |  | | | |
| Diabetes | | | | | | |  | | | |
| Asthma | | | | | | |  | | | |
| **Cervical Smear Record (women over 16 only)** | | | | | | | | | | |
| When was your last smear test | | |  | | | Do you use any form of contraception | | | |  |
| Have you had a hysterectomy | | |  | | | If yes which form of contraception | | | |  |
| How many children have you had | | |  | | | If a coil when was it fitted | | | |  |

**Repeat Medication -** Please list below all repeat medications prescribed to you

|  |  |  |
| --- | --- | --- |
| **Name of medication** | **Strength** | **Dosage** |
|  |  |  |
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**DOCUMENTATION REQUIRED WHEN REGISTERING AT RYE MEDICAL CENTRE**

**Evidence of Identity -** Driving Licence, Passport,Birth certificate or Marriage Certificate.

**Evidence of Address –** Tenancy Agreement, Council Tax Bill, recent Utility Bill, Solicitor Completion Letter, Bank statement.

**Evidence of Status (overseas patient) –** Visa/Residence permit/work Permit.