Adult Registration Form

Patient Name:…… **D.O.B:……..**

Mobile: ……

I give explicit consent for the GP Surgery to contact me via text message. Please sign below
(If you do not wish to give consent please speak to reception)

Patient Signature:…… **Date**:……

Proof of Identity and Address Provided?

Birth Certificate	Driving Licence	Passport	Utility Bill
Allowance Book	Solicitors Letter	Offer of tenancy	Other

Summary Care Record

Do you wish to opt out? Yes / No
If you do no opt out of having a summary care record one will be created for you by default. If you would like to opt out please ask reception staff for an **OPT-OUT FORM**

Sharing of Medical Data

Care Data Programme - Sharing parts of your GP record with the National Health & Social Care information centre. If you do not wish for your data to be shared in this way Please visit https://www.nhs.uk/your-nhs-data-matters/ for more information.

Ethnic Group (please tick as applicable)

White	British / Irish / Other
Black	Caribbean / African / Other
Asian	Indian / Pakistani / Other

Chinese	(Please State)
Mixed	White & Black Caribbean / White & Black African / White & Asian / Other

Carer

Do you look after someone who is ill, frail, disabled or mentally ill? (if yes please give details) Yes / No
Does someone look after you? (if yes, who) Yes / No

Armed Forces

Have you served as part of Her Majesty's Armed Forces?
Yes / No If Yes: What is your status with the military, please circle: Military veteran Active duty military OR are you a member of a military family? Yes/No

Disability

Do you have a disability we need to be aware of?
Sight impairment Yes / No
Hearing impairment Yes / No
Other Yes / No Details:

Smoking

Do you smoke? Yes / No
If 'No', have you ever smoked? Yes / No if 'Yes', when did you stop?

If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per week?
Would you like help and advice on giving up smoking? Yes/ No

Social Worker

Have you had an allocated social worker added to your family?
Yes / No

Next of Kin

Please give details of next of kin	
Name: Relationship: Address: Contact Details:	
Is your next of kin aware their details will be added to your medical record (please tick the box if yes)	

Online Services

Would you be interested in joining our online services? This means that you can order your medication online, book GP appointments and access a brief summary of your medical history. Yes / No

Nominated Pharmacy

Please give details of your nominated pharmacy
Name: Address:

Staff Only

Date Received:
Staff Name: