Stade Street
Hythe
Kent
CT21 6BD

Telephone 01303 235300

www.oaklandshealthcentre.com

New Patient Registration Form

Welcome to the Oaklands Health Centre

We aim to help you stay healthy and look after you when you are not.
If you have any ongoing medical problems, please make an appointment to see one of the doctors.

Name:										
Date of Birth:										
Address:										
Postcode:										
Home Phone No:										
Mobile No:										
Email:										
NHS Number: (eg: 012 345 6789)	N	N	N	N	N	N	N	N	N	N
Have you ever been a patient here before? ☐ Yes ☐ No										

Please inform the surgery promptly about
a change of address or contact numbers

PLEASE NOTE

We reserve the right to decline patients who do not attend their appointments

Patient Ethnic Origin Questionnaire

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Please indicate your first language:

If English is not your first language do you require an interpreter? ☐ Yes ☐ No

White

☐ British ☐ Irish

☐ Any other white background please specify:_____

Mixed

☐ White & Black Caribbean ☐ White & Black African

☐ White and Asian

☐ Any other white background please specify: _____

Asian or Asian British

☐ Indian ☐ Pakistani ☐ Bangladeshi

☐ Any other Asian background please specify: _____

Black or Black British

☐ African ☐ Caribbean ☐ White Asian

Chinese or other ethnic group

☐ Chinese

☐ Any other white background please specify: _____

Electronic Prescribing - This surgery operates an electronic prescribing service. We need you to choose where you want your GP to send your electronic prescription to. You can nominate one pharmacy and one appliance contractor (e.g. stoma/catheter appliances)

Collect from surgery ☐ Yes ☐ No

Collection from Pharmacy ☐ Yes ☐ No **If yes, which one?**

☐ Paydens ☐ Eakins ☐ Boots

☐ Other (please specify) _____

Appliance Contractor: _____

Repeat Medication - Please list below any repeat medication you are taking with the exact strength and instructions. You may need to see the doctor before your first prescription is issued. Alternatively please enclose a copy of your medication list from your last doctor

Allergies

Are you allergic to any medicines? ☐ Yes ☐ No

If so, which ones?

Weight	st	lb	OR	kg
Height	ft	in	OR	cm

Alcohol Status

1. How often do you have a drink containing alcohol?

   0 ☐ Never

   1 ☐ Monthly or less

   2 ☐ 2 - 4 times a month

   3 ☐ 2 - 3 times a week

   4 ☐ 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

   0 ☐ 1 or 2

   1 ☐ 3 or 4

   2 ☐ 5 or 6

   3 ☐ 7 to 9

   4 ☐ 10 or more

3. How often do you have six or more drinks on one occasion?

   0 ☐ Never

   1 ☐ Less than monthly

   2 ☐ Monthly

   3 ☐ Weekly

   4 ☐ Daily

Smoking Status

☐ Never Smoked

☐ Ex-Smoker When did you stop smoking: _____

☐ Current smoker How many do you smoke a day: _____

How many years have you smoked: _____

If you are a current smoker and would like to stop we are here to help.
Please make an appointment with one of our health care professionals for advice

Female Patients

If applicable, please indicate which form of contraception you are currently taking

☐ Oral Contraceptive (Pill Name): _____

☐ Coil – Type of coil: _____

☐ Contraceptive Injection ☐ Contraceptive Implant

If you are aged 25-64 date of your last cervical smear _____

Family History - Are there any illnesses (particularly heart disease, diabetes, high blood pressure and strokes) that run in the family, and who does this affect?

Current Medical History

Do you have or have you ever had (and when) any of the following, if yes please tell us when

- ☐ Asthma _____
- ☐ COPD or any other chronic lung problem _____
- ☐ Diabetes _____
- ☐ Heart disease (heart attacks or angina _____
- ☐ High blood pressure _____
- ☐ Stroke or mini-stroke _____
- ☐ Epilepsy or any nervous disorders _____

  Date of last fit: _____

  Frequency of fits: Daily / Weekly / Monthly / Yearly / Irregularly

- ☐ Cancer of any kind _____
- ☐ Thyroid Gland Disease _____
- ☐ Any operations: _____

  _____ _____

  _____ _____

- ☐ Any other ongoing condition: _____

  _____ _____

  _____ _____

Consent For Prescription Collection

Any patient wishing for someone else to collect their prescription will have to give the Practice signed consent. Reception staff will not be able to hand a prescription over to anyone collecting on someone's behalf without prior consent.

Please complete the appropriate box and then sign below

☐ **I GIVE** consent for _____
to collect prescriptions on my behalf

☐ **I DO NOT** give my consent for any 3rd party to collect prescriptions on my behalf

This consent is to remain in force until further notice or cancellation by me.
Print Full Name:
Signed:

NB. We are unable to hand out prescriptions to any person under the age of 15 on someone else's behalf

Consent to Discuss Medical Details

In accordance with the Data Protection Act, the Practice must have written permission from patients to allow us to discuss their medical treatment with a third party.

Please complete the appropriate box and then sign below

☐ **I GIVE** my permission for the Practice to discuss my medical treatment with the person/persons named below:

Name(s)

_____

_____

_____

☐ **I DO NOT** consent for the practice to discuss my medical treatment with a third party.

This consent is to remain in force until further notice or cancellation by me.
Print Full Name:
Signed:

Consent to Leave Messages

In accordance with the Data Protection Act, the Practice must have written permission from patients to allow us to leave messages on answerphones or with a third party.

Please complete the appropriate box and then sign below

☐ **I GIVE** my permission for the Practice to leave messages on my answerphone

☐ **I DO NOT GIVE** my permission for the Practice to leave messages on my answerphone

This consent is to remain in force until further notice or cancellation by me.
Print Full Name:
Signed:

Next of Kin Details

This will enable us to contact your next of kin in the event of an emergency

	First Next of Kin	Second Next of Kin
Name of next of kin:		
Relationship to you:		
Address:		
Postcode:		
Home Phone No.:		
Mobile No.:		
Email:		

Please Note: This information is for emergency contact only; no medical details will be discussed unless you have previously given permission.

Summary Care Record

On registering at the surgery patients are automatically given an electronic Summary Care Record. This is an NHS initiative which improves the way your health information is stored and managed.

Staff will only be permitted to access information, via strict security measures, if they are involved in your treatment. The Summary Care Record will be available anywhere in England and healthcare staff will ask for your permission before they use it.

Having a Summary Care Record will help ensure the right people have the right information at the right time. If you are happy to participate in this initiative you do not have to do anything further.

☐ **I have read and understand the above statement**
Print Full Name:
Signed:

If you choose not to have a Summary Care Record please indicate this below.
You can change your mind at any time.

☐ **I do not wish to have a Summary Care Record**
Print Full Name:
Signed:

FOR CHILDREN UNDER THE AGE OF 16 YEARS

Agreement will be assumed unless the parent/guardian opts out on their behalf.

If you wish to opt out please tick the box below and provide the details required.

☐ **I do not wish my child to have a Summary Care Record**
Childs Name:
Parent/Guardian:

Accessible Information Standard

The aim of this standard is to ensure that disabled people have access to information they can understand and the communication support they may need. We will ask patients and carers if they have any information or communication needs and find out how to meet those needs. We will record these needs in a set way, highlight this requirement on their medical records, share this information with other NHS and adult social care providers (if we have consent to do so) and ensure that people get the information in an accessible way and provide communication support.

For our records purposes please reply to the questions below:

Do you or your carers have any communication/information needs relating to a disability, impairment or sensory loss, and if so, what are they:

_____

_____

Are you happy for this information to be shared with other NHS and adult share care providers so they are aware of your needs? **YES** ☐ **NO** ☐

I confirm that I agree to my communication/information needs being shared with other NHS or adult care service providers for ongoing medical care.

Print Full Name:	
Signature:	**Date:**

Do You Have a Carer?

What do we mean by carer?

A Carer can be someone who looks after and supports you due to hearing or sight problems, age, mental or physical disability.

A Parent Carer of a disabled child, often seen as parents rather than carers.

A Young Carer is someone who is under the age of 18. They are often the person caring for a parent

Are you are carer for someone? **YES** ☐ **NO** ☐

Do you have a carer? **YES** ☐ **NO** ☐

If the answer is yes to either of the above questions and would like your carer's name to be added to our register please ask at reception for a leaflet.

Friends of Oaklands Health Centre

The surgery has a very active patient participation group. All patients are members and we are your voice. We are a friendly, helpful group who are keen to encourage a two-way communication between patients, doctors, nurses and staff.

Do come along and join us at one of our coffee mornings at Oaklands on the first Monday of the month in the Randall Davis room (upstairs in the surgery). The coffee mornings run from 10.00am – 11.30am. You will find more information on our notice boards in the downstairs waiting room. There is also a PPG suggestion for any comments in the entrance area at the Stade Street entrance.

We can also be found on www.hythe-gp.co.uk and on Facebook. We look forward to seeing you soon.

Thank you for taking the time
to complete this form.

- You will need provide a photocopy of two types of ID
    - Proof of address
    - Photographic ID