THE HAVEN PRACTICE

Patient Registration Form for 11 to 16 years

Your Named Accountable GP who is responsible for your care is Dr Larissa Tate

Surname:	Forename:
Date of Birth:	Landline:
Mobile No:	E-Mail:
INFORMATION ABOUT YOU Do you have a Carer? Are you a Carer? Are you Registered Disabled? **ILLNESSES:** Have you had any serious illness? Do you have any medical problems at the moment? Please list any allergies you have: Please list any tablets, medicine or other treatments you are taking or bought from a chemist: Are there any serious diseases that affect your family?	
PERSONAL INFORMATION **Next of Kin:** Name: Relationship: Contact Details including address;	
Religion	

IMMUNISATIONS: Please circle which Immunisations you have been given:	I
Diptheria/Tetanus/Polio	Measles/Mumps/Rubella
Pertussis (Whooping cough)	Meningitis B
HPV (Cervical Cancer)	Meningitis C
Rotavirus	Hepatitis B
Haemophilus(Hib)	Pneumococcal

SMOKING:

Do you smoke?

If 'No', have you ever smoked?

If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke Per week?

Would you like advice on giving up smoking?

ALCOHOL:

1 drink = 1/2 pint of beer or 1 glass of wine or 1 single spirits

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?

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

How often during the last year have you failed to do what was normally expected of you because of drinking?

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

Approx. weight and height?	Weight: Height:
Are you on any special diet?	

Ethnic Group(Please tick)

White British ☐ Irish ☐ Other

Black Caribbean ☐ African ☐ Other

Asian Indian ☐ Pakistani ☐ Chinese ☐ Other

Mixed White + Black Caribbean ☐

White + Black African ☐

White + Asian ☐

Other

Communications

I consent to the Practice contacting me by:

Email □ Yes □ No

Purpose of Newsletters, Repeat Prescriptions, General matters

Text □ Yes □ No

Purpose of Appointment Reminders, Health Check invitations

Electronic Prescription Service: Pharmacy Nomination

The Electronic Prescribing Service allows us to send your prescription forms electronically to your nominated, preferred choice of local pharmacy to be made up and collected at your convenience. Please ask reception for a leaflet for further information.

Pharmacy Nomination:	
Pharmacy Post Code:	
Patient Name:	

I am the patient/carer of the patient named above. Nomination has been explained to me and I have also been offered a leaflet that explains the nomination process.

Signed_____Dated_____

Data Sharing Consent Choices

To maintain continuity of clinical care, we upload certain medical information so that it is available to other healthcare organisations (e.g. Emergency Departments). Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations.

If you wish to OPT OUT please ask the Receptionist for a leaflet to complete

Special Information and Communication Needs

Do you have a Disability, Impairment or Sensory Loss and nee to receive information in a way you can easily understand?

Please tick: ✓

Please let us know of any Services you may require:

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Patient Online Registration Form
Access to GP online services for 11 to 16 years

Surname			
First name			
Date of birth			
Address			
Postcode			
Email address			
Telephone number		Mobile number	

I wish to have access to the following online services (tick all that apply):

Booking Appointments	☐
Requesting Repeat Prescriptions	☐
Accessing Detailed Coded Read Access Excluding free Text, letters and documents	☐

Proxy Access

All patients attaining the age of 11 years will be required to apply for access for this service to be continued. If the Patient is between the age of 11 and 16 they can consent to the person holding Parental Responsibility to have access, please complete below.

Name of person holding Parental Responsibility:	
I consent to the person above holding Parental Responsibility to have access to my records:	
Signature: Date:	

Application for Online Access to my medical record

I wish to access my medical record online and understand and agree with each statement (please tick)

❖ I have read and understood the information on the reverse of this form	☐
❖ I will be responsible for the security of the information that I see or download	☐
❖ If I choose to share my information with anyone else, this is at my own risk	☐
❖ I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
❖ If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	☐

Signature		Date	

For practice use only

Identity verified through (tick all that apply)	Vouching ☐ Vouching with information in record ☐ Photo ID ☐ Proof of residence ☐	Name of verifier	Date
Name of person who authorised (if applicable)			Date

January 18