

Montpelier Surgery Family Doctor Services Registration

Please fill out all fields in BLOCK CAPITALS

Title _____ Surname _____

Date of Birth

d	d	m	m	y	y
---	---	---	---	---	---

First Names _____

Town of Birth _____

Country of Birth _____

Current Address

Flat No: (if applicable) _____ House Number _____ Postcode _____

Street Name _____ Telephone Number _____

Please fill this section out as accurately as possible as we use it to locate your medical records.

Your Previous Address

Postcode _____

Name and Address of Previous Doctor

If you are from abroad please give the date you first came to live in the UK. ___/___/___

If Previous Resident in UK date of leaving ___/___/___

Your NHS Number

--	--	--	--	--	--	--	--	--	--

And date returned to live in UK ___/___/___

Other Contact Details and Consents

Telephone Number _____ Mobile Number _____

The Montpelier Surgery contacts their patients regarding appointment times and pathology results by SMS text message . All contact information regarding our patients is held as strictly confidential and will never be passed on to any third party. If you do **not** wish to be contacted by these methods please indicate below. If you leave this blank then you will automatically be opted IN.

I DO CONSENT I DO NOT CONSENT

Occasionally where appropriate we might contact you via email. If you would like to be contacted via this method please add your email address here _____

Online Services

We offer an online service for making and cancelling appointments as well as ordering repeated medication. If you would like to use these please indicate. If left blank you will automatically be opted OUT.

I WOULD LIKE TO BE REGISTERED I WOULD NOT LIKE TO BE REGISTERED

Additional Details

What is your main spoken Language? _____ Would you require an Interpreter? YES/NO

Next of Kin—Please give details of whom to contact on your behalf in an emergency.

Name _____ Relationship to you _____

Contact Number _____ Date of Birth _____

Lifestyle

Marital Status : Single Married Divorced Living with Partner Widowed

Occupation: Employed Unemployed Retired Other: (please specify) _____

If you are Employed please state your occupation (eg Teacher) _____

Do you Smoke? YES NO If YES please specify amount _____ Per Day

Are you an Ex-Smoker? YES NO If YES please specify amount _____ Per Day

Alcohol Screening - please tick to indicate answer

How many units do you drink per week? _____ units (1 unit = 1/2 pint of beer/ 1 med glass wine/ 1 spirit measure)

MEN: How often do you have EIGHT or more drinks on one occasion? Never () Montly () Weekly () Less than Monthly () Daily or almost daily ()

WOMEN: How often do you have SIX or more drinks on one occasion? Never () Montly () Weekly () Less than Monthly () Daily or almost daily ()

How often during the last year have you been unable to remember what happened the night before because you had been drinking? Never () Montly () Weekly () Less than Monthly () Daily or almost daily ()

How often during the last year have you failed to do what was normally expected of you because of drinking? Never () Montly () Weekly () Less than Monthly () Daily or almost daily ()

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? No () Yes, on one occasion () Yes, on more than one occasion ()

Medical and Family History

Please indicate below if you or a member of your family have suffered from any of the conditions listed below

Condition	You (Date of Diagnosis)	Family (Date of Diagnosis)
Heart Attack / Angina/ Other Chronic Heart Disease		
Heart Failure		
High Blood Pressure requiring medication		
Stroke () Transient Ischaemic Attack ()		
Diabetes: Type 1 () Type 2 ()		
Asthma requiring inhalers		
Chronic Obstructive Pulmonary Disease (COPD)		
Epilepsy		
Hypothyroidism		
Chronic Kidney Disease (Please indicate Stage 1-5)		
Depression requiring medication		
Schizophrenia/Bipolar/ other psychoses		
Cancer		
Dementia (Alzheimer's / Parkinson's)		

Other Information

Are you currently taking any medication? If so please specify

Do you have any allergies? Please give details

Feedback

The practice is always keen to hear your feedback on any aspect of our service. Please use the online feedback form at www.montpeliersurgery.co.uk, speak to the Practice Manager, Gary Toyne or speak to any member of our team.

For those keen to get more involved we are setting up a "Patient Reference Group". We know that it is hard for patients to come in to the surgery for meetings so we would like to contact you by email or by post. We may also invite you to meetings but of course your attendance would not be compulsory. We would like to ask your opinion on changes to your surgery and give you the opportunity to become more involved if you would like to do so. There is no time commitment involved!

Interested?... Please email our Practice Manager, Gary Toyne at gary.toyne@nhs.net. Please include in your reply any questions you think we should ask in a Patient Survey.

Patient Signature _____

Signature On Behalf of Patient _____

Name _____

Relationship to Patient _____

Date ____/____/____

<p>For Office Use ONLY</p> <p>You must see two forms of ID:</p> <p>1) Photographic ID</p> <p>2) Proof of residency in the Practice Area i.e proof of address</p> <p>Tick below to indicate which you have seen</p>	
British Passport valid and seen?	
EU Passport valid and seen?	
Other valid Passport seen and photocopied	
Proof of address within catchment area	
Offered New Patient Medical	
Patient informed of registration process	