CONFIDENTIAL MEDICAL REGISTRATION FORM
DR C P KHATRI & PARTNERS

Please complete this form in full and hand to the receptionist before your next appointment. This will help with your treatment before your full medical records arrive

Title:		
All first names: (in full)		
Surname:		
Any previous surnames:		
Date of Birth:		Male ☐ Female ☐
Town & Country of Birth		
NHS Number:		
Home Address:		
Postcode:		
Home Telephone No	**(Please ensure that you let us know if this number changes**	
Mobile No	**(Please ensure that you let us know if this number changes**	
Work Telephone No	**(Please ensure that you let us know if this number changes**	
Email Address:		
Name of next of kin		
Next of kin Tel No	**(Please ensure that you let us know if this number changes**	
Relationship to you		

We may text you if you have a mobile phone number but if you prefer not to receive texts from the surgery;

please tick here: ☐

We may wish to send you emails about the practice (not your personal health care). If you prefer not to receive emails from the surgery, please tick here: ☐

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Please help us trace your previous medical records by providing the following information

Your previous address in the UK:		Postcode:
Name and address of previous doctor/surgery:		Postcode:

If you are from abroad

Date you first came to UK	

Could you please describe your ethnic origin. Tick a box (one only please)

	✓ Tick Box Below		✓ Tick Box Below
British or mixed British		African	
Other White background		Asian	
Caribbean		Chinese	
Other mixed		Other black background	
Other – please state			

Signature of Patient: ____ **Date:** _____________________

Signature on behalf of Patient: ________________________________ **Date:** _____________________

PLEASE RETURN THIS FORM TO RECEPTION

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CONFIDENTIAL LIFESTYLE QUESTIONNARE

Supplementary information to help us give you the best medical care

Height:	(_______ft _______ins) OR (_______metres _______cms)
Weight	(_______stones _______.lbs) OR (_______kgs)
Blood Pressure	_______________________________
Personal Medical History.	Have you ever suffered from any important medical illnesses, operations or admission to hospital? If so please give details below:
Smoking	Which of the following best describes your smoking habits?

Never smoked?			
Ex-smoker		When did you quit?	
Smoker?		How many a day?	

Alcohol

SCORE	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
How many units of alcohol do you drink on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 or 8	10 or more
How often do you have 6 or more units if female, or 8 or more if male, in a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

A score of 5 or more suggests alcohol consumption is at a level of risk for dependency.

Allergies	Do you have any allergies? Please give details:
Disability	Do you have any disabilities that we should be aware of? Yes ☐ No ☐ If this disability affects your ability to access our services, please let us know and we will contact you to discuss this. Would you like someone to contact you? Yes ☐ No ☐
Ensuring Accessible Information	Do you have any particular information or communication support needs? Yes ☐ No ☐ We may be able to offer you support in accessing our services by other means if this is helpful. For example, by making appointments online rather than by telephone, by receiving emails or texts rather than a phone call with information or reminders, by arranging for an interpreter. Please let us know how we can help you. Are you happy for us to include this information in your patient record, and to share with other health professionals? Yes ☐ No ☐

CARER

Are you a carer for an elderly and/or disabled person who could not cope without your help? Yes ☐ No ☐

If '**YES**' who do you care for? ___________________________________ Relationship: ___________________________

Contact Details of person you are caring for: ____
(please give name and contact details plus details of relationship eg Mother, Father, Brother, Spouse, Child, Sister, Friend etc)

Are you being cared for? Yes ☐ No ☐

If **'YES'** who cares for you? ___________________________________ Relationship: ___________________________

Contact Details of person who is caring for you: ____
(please give name and contact details plus details of relationship eg Mother, Father, Brother, Spouse, Child, Sister, Friend etc)

Are you happy for us to discuss your medical records with them? Yes ☐ No ☐

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YOUR PATIENT RECORD

Summary Care Record

Once you have registered with the Surgery it will be assumed that you are happy to have your Summary Care Record shared with health care staff within the NHS ((eg. Emergency departments) unless you have already opted out or would like to take steps to opt out. If you would like more information, please ask reception for a leaflet.

Please tick here if you would like to opt out. ☐

On-line Services for Patients

We provide on line services for our patients. These services enable you to order repeat prescriptions, make appointments and view your patient record on line. If you would like to register for these services please complete the section below.

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

Booking appointments ☐   Requesting repeat prescriptions ☐   Accessing my medical record. ☐

I understand and agree with each statement:

I have read and understood the information leaflet provided by the practice. ☐

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 ☐

If I suspect that my account has been accessed by someone without my agreement,

I will contact the practice as soon as possible. ☐

If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible. ☐

If I think that I may come under pressure to give access to someone else unwillingly,

I will contact the practice as soon as possible. ☐

Signature of Patient: ________________________________   **Date: ____________________________**

Signature of Patient: ________________________________   **NHS No.: _________________________**

Thank you for filling in our questionnaire. When returning please ensure you provide photographic ID such as driving licence or passport AND a document to confirm your address, such as a utility bill, bank statement or rent book.

Staff to complete:

Type of photo ID checked, i.e. Passport/Driving Licence/Other ID and document number

____

Proof of address checked _____________________________

Signed ____   **Date: ___________________________**