Greens Norton & Weedon
Medical Practice

Weedon Surgery: 57 New Croft, Weedon, Northampton NN7 4RX
Tel: 01327 340212
Greens Norton Medical Centre: Towcester Road, Greens Norton, Towcester, NN12 8BL
Tel: 01327 358287
Website: www.gnwmp.co.uk

NEW PATIENT REGISTRATION FORM

Please tick the appropriate tick boxes.

PERSONAL DETAILS	
Full Name	
Date of Birth	
NHS Number	
Telephone Number	
Mobile Number	
	Please tick this box if you **DO NOT** want to receive SMS correspondence from the practice ☐
Alternative Number (if applicable)	
Email Address Please provide an email address if you are happy for us to use this as a means of contact. It is your responsibility to ensure access to your emails is secure.	

SYSTMONLINE	
Would you like to sign up to SystmOnline? This will allow you to book appointments and order medication online. If yes, you will be required to present photo ID to reception in person.	Yes ☐ No ☐

MEDICATION	
Are you currently on any repeat medications? If yes, please contact reception to make an appointment to speak to a GP.	Yes ☐ No ☐
Do you live more than one mile from a pharmacy? If yes, you will be added to the practice's dispensing patient list so you may collect your medication from the dispensary at the practice. If no, you are a non-dispensing patient so you will need to collect your medication from a local pharmacy. Please nominate a pharmacy for your prescriptions to be sent to:	Yes ☐ No ☐ …………………………………..

Full Name:
Date of Birth:

MEDICAL HISTORY	
Do you have any allergies? If yes, please provide details:	Yes ☐ No ☐ ....
Smoking Status	I have never smoked tobacco ☐ I smoke ☐ Would you like help to give up smoking? Yes ☐ No ☐ I am an ex-smoker ☐

SOCIAL WORKER	
Have you ever had, or currently have, a Social Worker involved in your family?	Yes ☐ No ☐

CARER	
Do you look after someone? Does someone look after you? If yes, please ask reception for a Carers Information Pack.	Yes ☐ No ☐ Yes ☐ No ☐

MILITARY VETERAN	
Are you a military veteran?	Yes ☐ No ☐

NEXT OF KIN	
If you have a Next of Kin, whose details you would like to add to your medical record, please complete the following:	
Full Name	
Relationship	
Contact Number	

THIRD PARTY CONSENT	
Do you wish for somebody to have consent to access your medical record and liaise with the practice on your behalf? If yes, please ask reception for a third party consent form.	Yes ☐ No ☐

SUMMARY CARE RECORD	
A Summary Care Record (SCR) is an electronic patient record. Your SCR contains name, address, date of birth, NHS number, information about medicines, any bad reaction to medicines and allergies. Allowing access to this information improves decision making in all settings where you receive healthcare. You can choose to have a SCR or choose to opt out.	
Do you have an existing Summary Care Record? **Do you wish to Opt-Out?** If yes, please complete the Opt-Out Form.	Yes ☐ No ☐ Yes ☐ No ☐
Do you have any information or communication support needs relating to a disability, impairment or sensory loss? If yes, how can we best meet those needs?	Yes ☐ No ☐ ....

Full Name:
Date of Birth:

Do we have your consent to include those support needs in your Summary Care Record?	Yes ☐ No ☐

ETHNIC CATEGORY

Please indicate your ethnic category below. This is designed to 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. This information will be added to your computer health record and will remain confidential. Choose ONE category, and then tick the box to indicate your ethnic category. If asked to specify, please do so as fully as possible.

White	**Black or Black British**
British or Mixed British ☐	Caribbean ☐
Irish ☐	African ☐
Other White Background **(Please Specify)** ☐	Other Black Background **(Please Specify)** ☐ ....
Mixed	**Asian or Asian British**
White and Black Caribbean ☐	Indian ☐
White and Black African ☐	Pakistani ☐
White and Asian ☐	Bangladeshi ☐
Other Mixed Background **(Please Specify)** ☐	Other Asian Background **(Please Specify)** ☐ ....
Other Ethnic Groups	**Not Stated**
Chinese ☐	Not stated ☐
Other Ethnic Group **(Please Specify)** ☐	

SIGNATURE		**DATE**	

FOR STAFF USE ONLY:

☐ New Patient Health Check appointment made
☐ Repeat Medication appointment made
☐ Summary Care Record consent updated
☐ Allergies added
☐ Smoking status added
Notes Requested Yes ☐ No ☐
☐ GMS1 initialed

Completed by: .... Date: ....