BEACON MEDICAL GROUP

Plympton Medical Practice
Ivybridge Medical Practice
Chaddlewood Medical Practice
Wotter Medical Practice
Glenside Medical Practice
Highlands Health Centre

NEW PATIENT QUESTIONNAIRE

The information that we are seeking on this form is to help us offer you the best advice and treatment that we can. Please tell us as much as you can and return this form to the surgery together with the registration form and documents to verify your identity. We can then book an appointment for your new patient check.

ABOUT YOU

Date of Birth		Title	
Surname		Forename(s)	
Previous Surname		Occupation	
Address Post Code		Home Phone	
		Mobile Phone	
		E-Mail Address (We may contacted you by email for practice marketing purposes)	

Marital Status (circle as appropriate)	Married or Civil Partnership	Widowed	Divorced or Separated	Single
Details of parent or guardian (if under 18)				
Are you a military veteran?				
Usual Branch	**Plympton** **Chaddlewood** **Glenside** **Wotter** **Ivybridge** **Highlands**			

WHY WE NEED TO VERIFY YOUR IDENTITY

It is not uncommon for people to use false names to register with practices and then obtain prescription drugs fraudulently. This costs the NHS money and we need to play our part in attempting to combat this fraud.

It is now local NHS policy that all individuals seeking to register with practices in Plymouth, either as new patients or temporary residents, should provide proof of identity. This means verifying your name and also where you live or used to live.

Acceptable documents for proof of name are:

- Passport
- Driving licence
- Birth certificate
- Marriage certificate
- NHS card
- Local authority rent card
- National insurance number card

Acceptable documents for proof of address are:

- Council tax payment book or correspondence
- Bank or credit card statements
- Utility bills (gas, electricity or land line telephone)

When returning your completed registration form and new patient questionnaire please present one document to verify your name and another to verify your address.

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Identification provided	Y/N			Summary Care Record Opt-out coded (if appropriate)	Y/N
Questionnaire responses checked by		Date of registration			
Smoking cessation advice given	Y/N			Read-coded by	
Smoking cessation literature given	Y/N	First language coded	Y/N	Scanned	Y/N
Date of new patient check appt		Ethnicity coded	Y/N	Audit to GP	Y/N

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YOUR ETHNIC GROUP – How would you describe your ethnicity? (circle the appropriate group)

White British	White Irish	Other White Background	
Mixed White and Black Caribbean	Mixed White and Black African	White and Asian	Other Mixed Background
Indian	Pakistani	Bangladeshi	Other Asian Background
Caribbean	African	Other Black Background	
Chinese	Other Ethnic Group		Declined To Say

YOUR FIRST LANGUAGE

First Language	
Consultations are carried out in English. Please indicate if you will need the services of an interpreter	Yes / No

YOUR HEIGHT AND WEIGHT

Height (indicate units used e.g. feet & inches or cms		Weight (indicate units used e.g. stones & pounds or kgs	

Smoking

Do you smoke?	Yes/No	Have you ever smoked?	Yes/No
If you are an ex-smoker:			
When did you stop? (approx month & year)		How much did you smoke before giving up? (cigarettes/day or grams tobacco/week)	
If you are a current smoker:			
What do you smoke? (delete as appropriate)	Cigarettes/cigars/pipe	How much do you currently smoke? (cigarettes/day or grams tobacco/week)	
Would you like help to stop smoking?	Yes/ No	If you are a smoker and you wish to have help stop smoking, please make an appointment with one of our smoking advisors for help and advice.	

Continued Overleaf

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Alcohol - Alcohol use can affect your health and can interfere with certain medications and treatments.
Your answers will remain confidential so please be honest.
Use the guide below to decide how many **units** you drink a week.

Pint of regular Beer / Lager / Cider	**2 units**
Alcopop or Can of Lager	**1.5 units**
Glass of Wine (175ml)	**2 units**
Single Measure of Spirits	**1 unit**
Bottle of Wine	**9 units**

Alcohol

How many units of alcohol do you consume in an average week?	

Alcohol

Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Your Total Score	

Scoring:
A total of 5+ indicates increasing or higher risk drinking.
If your score is 5+ you may be asked to fill in a further questionnaire during a New Patient Check appointment with one of our nursing team.

Continued Overleaf

YOUR MEDICAL HISTORY

Do you live with any of the following conditions? (please provide approximate date of diagnosis below)			
Diabetes Type 1	Diabetes Type 2	Hypertension (high blood pressure)	Epilepsy
Heart Disease	Mental Health	COPD/Emphysema	Asthma
Cancer	Deafness/hard of hearing	Blindness/partial sight	
If so, when was your last check-up?			
Have you had any serious illnesses, accidents or operations?			
Please list all events with dates			
Are you allergic to anything? (e.g. aspirin, penicillin, bee stings, sticking plasters)			

YOUR FAMILY HISTORY

Have your parents, brothers or sisters had any of the following conditions before the age of 60?			
Diabetes		Asthma	
High Blood Pressure		Hay Fever	
Heart Attack		Epilepsy or Fits	
Stroke		Other Conditions	

CARERS AND THE CARED FOR

Are you a Carer?	Yes/No
If you are a carer, please state the name/ address/ and relationship of the person you care for.	
Is the person you care for registered with this practice?	Yes/No (delete as appropriate)
Signature	

Does someone care for you?

If someone else cares for you, it is important for us to hold this information in your medical record, please sign below if you wish us to disclose information about your health to your carer.

If you are cared for, please state your carers/ address/ your relationship with the person who cares for you.	
Is the person you care for registered with this practice?	Yes/No (delete as appropriate)
Signature	

Sharing your record

Patient Consent Form

We recognise the importance of protecting personal and confidential information in all that we do, and we will take care to meet our legal duties, as the law determines how organisations can use the personal information that we collect.

To support our statutory obligations, we must inform you of who we will share information with and allow you to determine whether or not you wish us to share the information that we have recorded about you within your patient record. You have the right to withdraw consent at any time and also to change who you wish us to share your information with. Should this be the case, we will inform the relevant partner organisations and advise them of your decision.

I, …… (Print Name), give/does not give (delete as appropriate) consent for my information to be shared to discuss the care that is provided to identify services and resources which could support my health and wellbeing.

For further information on who we share with and what steps we take to protect the information we hold, please speak to our patient advisors.

Please tick against each data set identifying if you wish/do not wish to share data

Record Sharing Initiative	I hereby give consent for my information to be shared.	I do not consent for my information to be shared.
Summary Care Record		
Care.Data		
Local Shared Care Record (local providers only)		

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Please ensure that the referring organisation is removed from the list of options above.
Ensure that a copy is provided to the patient, stored in the paper medical record and shared with the appropriate organisations.
Should the above named patient indicate that they wish to amend the organisations that they have consented to share with or that they have withdrawn consent completely, please ensure that a new form is completed with the revised choices and then share and store as previous.

Code 9Nu0 entered in patient's record (Dissent from secondary use of GP patient identifiable data)	Initials
Code 9Nu4 entered in patient's record (Dissent from disclosure of personal confidential data by Health and Social Care Information Centre) Initials	

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PATIENT ONLINE

NHS England

Patient Online Registration Form
Access to GP online services

Surname			
First name			
Date of birth			
Address			
Postcode			
Email address	(please ensure this is secure)		
Telephone number		Mobile number	

I wish to access by proxy online services (tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

Application for online access to my medical record

I wish to access my medical record online. In signing this form I confirm that I have read the advice in section 2 and understand and agree with each statement below (please tick)

1. I have read and understood the information on the reverse of this form	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. 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 completed patient record check:			Date

Created 06/14
Update 10/16

Section 2 - Important Information – Please read before returning this form

This form will take 10 working days from receipt to action. Once we have opened your record for you to access, your login details will be sent via email to the account you have stated on this form. If you have not supplied a secure email address then you can collect the login details from your local surgery at the Reception desk.

It will be your responsibility to keep your login details and password safe and secure. If you know or suspect that your record has been accessed by someone that you have not agreed should see it, then you should change your password immediately.

If you can't do this for some reason, we recommend that you contact the practice so that they can remove online access until you are able to reset your password.

If you print out any information from your record, it is also your responsibility to keep this secure. If you are at all worried about keeping printed copies safe, we recommend that you do not make copies at all.

Please note: If we have any reason to believe that in giving you online access this may cause you physical and/ or mental harm the practice reserve the right to refuse you online access. Patients records will be checked upon receipt of this form in order to verify details and carry out safeguarding checks in line with legislation. If we are unable to offer you online access this will be discussed with you by one of our Operations Managers.

Please request a copy of our Online Access Policy for full information in respect of our online services.

Section 3 - Before you apply for online access to your record, there are some other things to consider.

Although the chances of any of these things happening are very small, you will be asked that you have read and understood the following before you are given login details.

Forgotten history There may be something you have forgotten about in your record that you might find upsetting.
Abnormal results or bad news If your GP has given you access to test results or letters, you may see something that you find upsetting. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them. Please be assured anything that requires urgent attention will be actioned BEFORE it has been added to your patient record as information is added after review by a clinician.
Choosing to share your information with someone It's up to you whether or not you share your information with others – perhaps family members or carers. It's your choice, but also your responsibility to keep the information safe and secure.
Coercion If you think you may be pressured into revealing details from your patient record to someone else against your will, it is best that you do not register for access at this time.
Misunderstood information Your medical record is designed to be used by clinical professionals to ensure that you receive the best possible care. Some of the information within your medical record may be highly technical, written by specialists and not easily understood. If you require further clarification, please contact the surgery for a clearer explanation.
Information about someone else If you spot something in the record that is not about you or notice any other errors, please log out of the system immediately and contact the practice as soon as possible.

More information

For more information about keeping your healthcare records safe and secure please visit our website: www.beaconmedicalgroup.nhs.uk