**WHITTINGTON MOOR SURGERY**

**OUT OF AREA PATIENT REGISTRATION FORM (00AR)**

**Please fill in as much of the Registration form as possible, anything with a \* is compulsory**

**DEMOGRAPHICS** : NHS Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Date of Birth \_\_\_\_\_\_\_\_\_

Title: Mr Mrs Miss Ms Other \_\_\_\_\_\_\_\_\_\_\_\_ \*Sex: M / F \*Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Previous Surname/s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Town & County of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Postcode\_\_\_\_\_\_\_\_\_\_

\*Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Mobile Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:

\*Consent to receiving SMS Messages from us YES / NO Can we contact you via email YES / NO

\*What is your Ethnic Origin \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*What is your first language\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Previous Address in the UK:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Postocde:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Are You from Abroad? YES / NO.\*If previously resident in the UK, date of leaving: \_\_\_\_\_\_\_\_\_\_\_\_

\*Date you first came to live in the UK: \_\_\_\_\_\_\_\_\_\_\_

\*Name & Address of Previous GP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*If you are returning from the Armed Forces, The last base you lived at:

ARMY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (XaP9d) Service or Personnel Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAVY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (XaP9f) Enlistment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RAF \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (XaP9g) Discharge Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACCESSIBLE INFORMATION STANDARDS:**

\*Do you have any communication or information needs relating to a disability/impairment or sensory loss? Yes / No *(for surgery use only, if no Y17f3 / Yes Y17f2)*

If yes, please let us know what these are so we can do our best to support

you:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OCCUPATION**: (Present or Previous) :

**NEXT of KIN *(If you wish this information to be entered on your record)***

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CARERS:** Do you look after any of the following (who need support due to physical or learning disability/illness) Relative ☐ Child ☐ Friend ☐

*If yes and you would like more information please ask for our Carer’s leaflet – you may be entitled to free annual influenza vaccinations*

**SMOKING** Do you smoke? YES / NO or If no are you an Ex-Smoker *(please give date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

If Yes: Cigar / Cigarettes How many per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you interested in advice to help you stop smoking? YES / NO

SCR – Summary Care Record

“Your emergency Care Summary”

\*If you wish to have a Summary Care Record and additional details please tick the box ☐

If you would like any more information regarding this please ask the receptionist or visit www.nhscarerecords.nhs.net

**HOME VISIT DISCLAIMER FORM**

**Patient living Out of Practice Area**

**No Home Visits Allowed – this includes both GP and Practice Nursing Staff**

**I (Print Name) ………………….……………DOB .…………………** assume full responsibility for the decision to register / remain on Whittington Moor Surgery practice list after being informed that I am living outside the practice area therefore would not be eligible for In-hours home visits by the practice staff.

I sign below to confirm that I understand the risks & implications this has for me and I would need to contact NHS 111 if a home visit is required.

**Signed ………………………………………………………………………**

**Date …………………………………………………………………………**