



Stade Street,  
Hythe,  
Kent  
CT21 6BD

Telephone 01303 235300  
(day and night)  
[www.hythe-gp.co.uk](http://www.hythe-gp.co.uk)

## **New Patient Registration**

PLEASE BRING THIS FORM BACK TO THE  
SURGERY. DO NOT POST IT

## ***Welcome to the Oaklands Health Centre***

We aim to help you stay healthy, and look after you when you are not. If you have any ongoing medical problems please make an appointment to see one of the doctors.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Postcode: \_\_\_\_\_

Phone No: \_\_\_\_\_

Mobile: \_\_\_\_\_

E-mail: \_\_\_\_\_

Please inform the surgery promptly of any change of  
address or contact numbers

### Please Note

We reserve the right to decline patients  
who do not attend their appointments

## ***Current Medical History***

Do you have or have you ever had (and when) any of the following

- Asthma .....
- COPD or any other chronic lung problem .....
- Diabetes .....
- Heart disease (heart attacks or angina) .....
- High blood pressure .....
- Stroke or mini-stroke .....
- Epilepsy or any nervous disorders .....

Date of last fit: ..... Frequency of fits.....

- Cancer of any kind .....
- Thyroid Gland Disease .....
- Any operations .....
- Any other ongoing condition .....

.....

## ***Female Patients***

If applicable please indicate which form of contraception you are currently taking

- Oral Contraceptive (Pill Name).....
- Coil
- Contraceptive Injection
- Contraceptive Implant

If you are aged 25-64 please enter the approximate date of your last cervical smear .....

***Repeat Medication***

Please list below any repeat medication you are taking with the exact strength and instructions. You may need to see the doctor before your first prescription is issued. Alternatively please enclose a copy of your medication list from your last doctor.

***Electronic Prescribing***

This surgery operates an electronic prescribing service. We need you to choose where you want your GP to send your electronic prescription to. You can nominate one pharmacy and one appliance contractor (e.g. stoma/catheter appliances)

Pharmacy: \_\_\_\_\_

Appliance Contractor: \_\_\_\_\_

***Allergies***

Are you allergic to any medicines? If so, which ones?

## ***Alcohol Status***

1. 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

2. How many standard drinks containing alcohol do you have on a typical day?

- 1 or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more

3. How often do you have six or more drinks on one occasion?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

(If you would like to discuss your alcohol intake with a medical professional please make an appointment)

**Smoking Status**

Never Smoked

Ex Smoker  
(When did you stop smoking) .....

Current smoker  
(How many do you smoke a day) .....

(How many years have you been a smoker) .....

If you are a current smoker and would like to stop - we are here to help, please make an appointment with one of our health care professionals for advice.

**Weight** .....

**Height** .....

**Family History**

Are there any illnesses (particularly heart disease, diabetes, high blood pressure and strokes) that run in the family, and who does this affect?

# **Patient Ethnic Origin Questionnaire**

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory but may 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.

## **Please Indicate Your First Language**

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If your first language is not English will you require an Interpreter to communicate with a doctor?

**Yes**       **No**

### **White**

	British
	Irish
	Any other white background please indicate below

### **Mixed**

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background please indicate below

***Asian or Asian British***

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background please indicate below

***Black or Black British***

	Caribbean
	African
	White and Asian
	Any other Asian background please indicate below

***Chinese or other ethnic group***

	Chinese
	Any other white background please indicate below



**Consent**  
**For Prescription Collection**

Any patient wishing for someone else to collect their prescription will have to give the Practice signed consent. Reception staff will not be able to hand a prescription over to anyone collecting on someone's behalf without prior consent.

Please complete the appropriate box:

- I give** consent for .....  
to collect prescriptions on my behalf.
  
- I do not** give my consent for any 3<sup>rd</sup> party to collect  
prescriptions on my behalf.
  
- Not applicable.

**This consent is to remain in force until further notice or cancellation by me.**

**Signed:** .....

**Print Full Name:** .....

**NB. We are unable to hand out prescriptions to any person under the age of 15 on someone else's behalf**

**Consent**  
**to Discuss Medical Details**

In accordance with the Data Protection Act, the Practice must have written permission from patients to allow us to discuss their medical treatment with a third party.

Please complete the appropriate box:

**I give** my permission for the Practice to discuss my medical treatment with the person/persons named below

Name(s).....

.....

**I do not give** consent for the practice to discuss my medical treatment with a third party.

**This consent is to remain in force until further notice or cancellation by me.**

**Signed:** .....

**Print Full Name:** .....

## **Consent to Leave Messages**

In accordance with the Data Protection Act, the Practice must have written permission from patients to allow us to leave messages on answerphones or with a third party.

Please complete the appropriate box:

- I give** my permission for the Practice to leave messages on my answerphone
- I do not give** consent for the practice to leave messages on my answerphone

**This consent is to remain in force until further notice or cancellation by me.**

**Signed:** .....

**Print Full Name:** .....

### **Next Of Kin Details**

This will enable us to contact your next of kin in the event of an emergency

**Name:** ..... **Relationship:** .....

**Address:** .....

..... **Phone No:** .....

**Please Note:** This information is for emergency contact only and no medical details will be discussed with your NOK unless you have previously given permission.

## **Summary Care Record**

On registering at the surgery patients are automatically given an electronic Summary Care Record. This is an NHS initiative which improves the way your health information is stored and managed.

Staff will only be permitted to access information, via strict security measures, if they are involved in your treatment. The Summary Care Record will be available anywhere in England and healthcare staff will ask for your permission before they use it.

Having a Summary Care Record will help ensure the right people have the right information at the right time

As a patient you have choices:

If you are happy to participate in this initiative you do not have to do anything further. However **if you choose not to have a Summary Care Record please indicate this below.** You can change your mind at any time.

**I do not wish to have a Summary Care Record**

**Signature:** .....

**Print Full Name:** .....

**For children under the age of 16 years Agreement will be assumed unless the parent or guardian opts out on their behalf.**

**I do not/wish my child to have a Summary Care Record**

**Parent/Guardian:** .....

**Childs Name:** .....

## **Accessible Information Standard**

The aim of this standard is to ensure that disabled people have access to information they can understand and the communication support they may need. We will ask patients and carers if they have any information or communication needs and find out how to meet those needs. We will record these needs in a set way, highlight this requirement on their medical records, share this information with other NHS and adult social care providers (if we have consent to do so) and ensure that people get the information in an accessible way and provide communication support

For our records purposes please reply to the questions below:

Do you or our carers have any communication/information needs relating to a disability, impairment or sensory loss, and if so, what are they:

Are you happy for this information to be shared with other NHS and adult share care providers so they are aware of your needs?

**YES**       **NO**

I confirm that I agree to my communication/information needs being shared with other NHS or adult care service providers for ongoing medical care.

**Signature:** .....

**Print Full Name:** .....

**Date:** .....

## **Do You Have a Carer?**

What do we mean by carer?

**A Carer** can be someone who looks after and supports you due to hearing or sight problems, age, mental or physical disability.

**A Parent Carer** of a disabled child, often seen as parents rather than carers.

**A Young Carer** someone who is under the age of 18. They are often the person caring for a parent

**If the answer is yes to anyone of the above and you would like your carer's name to be added to our register please ask the Receptionist for a Carer's Leaflet.**

## **Friends of Oaklands Health Centre**

The surgery has a very active patient participation group. All patients are members and we are your voice. We are a friendly, helpful group who are keen to encourage a two-way communication between patients, doctors, nurses and staff.

Do come along and join us at one of our coffee mornings at Oaklands on the first Monday of the month in the Randall Davis room (upstairs in the surgery). The coffee mornings run from 10.00am - 11.30am. You will find more information on our notice boards in the downstairs waiting room. There is also a PPG suggestion for any comments in the entrance area at the Stade Street entrance.

We can also be found on [www.hythe-gp.co.uk](http://www.hythe-gp.co.uk) and on Facebook. We look forward to seeing you soon.

***Thank you  
for taking the time  
to complete this form.***