Willow Group

Patient Registration Form

CHECKED BY: DATE:

Site Submitted: Waterside □ Brune □ Stoke □ Forton □

Please complete this form in BLOCK CAPITALS and tick ✓ or delete as appropriate.

By giving us your current telephone number(s) and/or email address, you consent to us contacting you for medical or administrative reasons. We may also pass your details on to another NHS or NHS-partnered organisation to assist them in providing healthcare services for you as agreed between you and your doctor/nurse. We will never hand your information over to any non-allied organisation. This is our minimum level of communication we require from you. **We require you to keep us informed of any changes to your contact details.**

Online Services

Our system can now offer online appointments, medication requests, secure messaging to us and viewing your medical record. When we register you, we will email some security codes for you to enable your online account. Your email address will be used for security verification and confirmation receipts. This service can only be activated once you are fully registered with the practice. The codes will expire 30 days after sending.

Sharing Data

For more information about how we data, please see our Privacy Policy at www.thewillowgroup.nhs.uk. If you wish to opt out of sharing your data to other organisations, please see ask for an opt-out form at reception.

Communication Services

We will send you appointment reminders and recall invitations, eg for 'flu vaccinations or chronic disease management reviews via our texting/email service. Please be aware messages may be heard or read by other members of your household if you share telephones or email addresses.

I **do not** wish to have text message appointment reminders/invitations ○

I am happy to receive appointment reminders and invitations by text message ○

When registering you will be asked for a proof of ID, address, and residency

Your Details

Title*:
Mr ○ Mrs ○ Miss ○ Ms ○ Other _____

Date of Birth*:
_____

Surname*:
_____

Forenames*:
_____

Previous Surname:
_____

NHS Number:
_____

Gender*:
Male ○ Female ○

Home Telephone*:
_____

Town & Country of Birth
_____

Mobile Telephone*:
_____

Current Home Address:
_____

Work Telephone*:
_____

_____

Email*:
_____

_____ Post Code: _____

Next of Kin (Title and Full Name)
_____

Relationship of Next of Kin to you
_____

Next of Kin Address
_____

Next of Kin Contact Number
_____

Disabilities & Reasonable Adjustments

Do you have a disability? _____

Do you require any Reasonable Adjustments? _____

Preferred Pharmacy

Do you have a preferred pharmacy for us to send your prescriptions to electronically?

_____

Carers:

○ I am a Carer	○ I have a Carer

If you have a carer, please provide their contact details:

Name: Address: Telephone number:

If you would like a nominated person to have permission to discuss your medical records with us please supply a separate signed letter.

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

Previous Address in the UK: _____ _____ Post Code: _____
Previous GP's name whilst at that address: _____
Previous GP's Address: _____ _____ Post Code: _____

If you are If you are from abroad:

Your first UK address where registered with a GP: _____ _____ Post Code: _____	
Date you first came to live in the UK: _____	If previously resident in the UK, date you left: _____

If you are returning from the Armed Forces:

Address before enlisting: _____ _____ Post Code: _____		
Service/Personnel No: _____	Date of Enlistment: _____	Date of Leaving: _____

My ethnic origin is:

Having information about patients' ethnic groups would be helpful for the NHS so that we can plan and provide culturally appropriate and better services to meet patients' needs. If you do not wish to provide this information, you do not have to do so. You may indicate this by ticking the last box.

Your answer to this question will not affect your care.

○ White British	○ White Irish	○ White other	○ Any other mixed background
○ White & Black Caribbean	○ White & Black African	○ White & Asian	
○ Indian	○ Pakistani	○ Bangladeshi	○ Any other Asian Background
○ Caribbean	○ African	○ Any Other Black Background	
○ Chinese	○ Other ethnic group	○ Do not wish to state	

My speaking language is _____

What is your height?		m		ft		in
What is your weight?		kg		st		lb

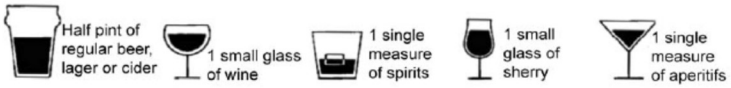
Smoking

Do you smoke?	Yes ☐	Never ☐	Ex-smoker ☐
If yes, what do you smoke?	Cigarettes ☐	Cigars ☐	Pipe ☐
How many do you smoke a day?			
How long have you been smoking for?			
Do you want help to give up smoking?	Yes ☐	No ☐	

Alcohol

How many units of alcohol do you consume per week? _____

This is one unit of alcohol…



○ I am a forces veteran

○ Signature of patient ○ Signature on behalf of patient Date

_____ _____

Don't forget to bring your proof of ID, address and residency!