MERTON MEDICAL PRACTICE
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Adult Registration Form

GUIDANCE FOR COMPLETING YOUR REGISTRATION FORM: PLEASE ENSURE YOU COMPLETE THIS FORM **IN FULL.** MISSING INFORMATION MAY RESULT IN THE REGISTRATION PROCESS BEING SIGNIFICANTLY DELAYED.

PLEASE BRING ONE OF THE FOLLOWING WITH YOUR COMPLETED APPLICATION: A COPY OF A RECENT PROOF OF ADDRESS (E.G. A BILL, BANK STATEMENT OR TENANCY AGREEMENT). PLEASE PROVIDE A COPY OF YOUR ID IF YOU ALSO WISH TO ACCESS ONLINE SERVICES.

Forename(s): Surname:	Date of Birth: Gender:
Main spoken language: Do you require an interpreter? ☐ Yes ☐ No Ethnicity:	Home Tel No: Mobile: Email address: Are you happy for us to email you regarding any health matter? ☐ Yes ☐ No
Next of kin: (Contact in case of Emergency) Name: Relationship: Contact number: Can your medical records be discussed with your next of kin? ☐ Yes ☐ No	
Do you have a carer? ☐ Yes ☐ No If Yes, please give details: Name: Telephone:	Are you a carer? ☐ Yes ☐ No If Yes, please give details: Name:
Height: Weight:	Allergies:
Do you have any health problems? ☐ Yes ☐ No If Yes, please give details: Are you currently on any medication? ☐ Yes ☐ No If Yes, please give details:	Do you have any Family History of: ☐ High Blood Pressure _____ ☐ Heart Disease _____ ☐ Diabetes _____ ☐ Cancer _____

Do you currently smoke? ☐ Yes ☐ No

If Yes, Number per day:____ Cigarettes / Tobacco / Cigars / Pipe

If you're an ex-smoker, when did you stop? Date_____

A new stop smoking helpline has been launched for Londoners who want help to quit. The helpline is open seven days a week – Monday to Friday from 9am to 8pm and on Saturday and Sunday between 11am and 4pm. Callers to the helpline (**0300 123 1044**) will be able to speak to a trained advisor to find out what support is available in their area and establish which quit methods best suit them.

(Women only)

Have you ever had a smear test in the UK (Pap Test)?

☐ Yes Please give approx.. date:_____

☐ No

Please book an appointment with the nurse if:

- Your last smear test was taken over 3 years ago (5 years if you're aged 65 or over)
- You never had a smear test and you are over 24
- Your last smear test was taken abroad

If you do not wish to have a smear test, please ask Reception to sign a disclaimer form.

Do you drink alcohol? ☐ Yes ☐ No

If yes, please complete the following questionnaire:

How much alcohol do you drink per week?

Beer: ____ pints Wine: _____ glasses Spirits: _____ measures

AUDIT-C QUESTIONNAIRE

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 - 8	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	

PLEASE ANSWER THE FOLLOWING QUESTIONS ONLY IF YOU HAVE SCORED 5 OR HIGHER IN THE

PREVIOUS QUESTIONNAIRE

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have 8 (men)/6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Only answer the following questions if your answer above is monthly or less						
How often in the last year have you not been able to remember when drinking what happened the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

STAFF USE ONLY:

Checker's Initials: _____ Date: _____

☐ Patient informed of named GP GP's Initials: _____

☐ Proof of Address Seen

☐ Online Access and SCR boxes Ticked

☐ Form Signed (4 signatures in total – 2 only if no online access)

☐ Practice Leaflet Given

☐ Smear test Appointment details/disclaimer:

Postnatal Appointment Details (if required):

Any other comment:

Would you like to have Online Access to your records? Yes □ No □

IF THIS IS YOUR FIRST REGISTRATION WITH A GP IN THE UK

Please take the Online Access form with you and submit the request in approximately 1 month time.

IF YOU HAVE BEEN REGISTERED BEFORE WITH A GP IN THE UK

You can submit your request now (in person only). Please make sure you provide a proof of ID.

NOTE TO PATIENT: PLEASE DO FILL THE BELOW ONLINE ACCESS FORM IF YOU ARE ABOUT TO SEND THIS REGISTRATION FORM VIA EMAIL AS WE WOULD BE UNABLE TO VERIFY YOUR IDENTITY. PLEASE PRINT THE FORM AND BRING IT IN WITH A PROOF OF ID INSTEAD.

Online Access to Medical Records

Before you apply for online access to your record, there are some 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.

- The practice has the right to remove online access to services for anyone that doesn't use them responsibly.
- 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.

Other things to consider

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 to you. This may occur before you have spoken to your doctor or while the surgery is closed and you cannot contact them.
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, you will find a helpful leaflet produced by the NHS in conjunction with the British Computer Society:
Keeping your online health and social care records safe and secure
http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/PatientGuidanceBooklet.pdf

I have read through and understand all the information provided in this document.

Signature:	Date:

Application for online access to my medical record

Surname	Date of birth
First name	
Address	
Email address	
Telephone number	Mobile number

I wish to have access to the following online services (please tick all that apply):

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

I wish to access my medical record online and understand and agree with each statement (tick)

1. I have read and understood the information leaflet provided by the practice	☐
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 is not about me or is inaccurate, I will contact the practice as soon as possible	☐

Signature:	Date:

For practice use only

Patient NHS number	Practice computer ID number

Identity verified by (initials)	Date	Method Vouching ☐ Vouching with information in record ☐ Photo ID ☐
Authorised by		Date
Date account created		
Date logins sent		
Level of record access enabled		All ☐ Prospective ☐ Retrospective ☐ Detailed ☐ Limited parts ☐ Contractual minimum ☐