The Peninsula Practice

New Patient Registration Form www.thepeninsulapractice.co.uk

Title:		Date of Birth:	
Surname:		Place of Birth:	
First Name(s):		Occupation:	
Previous Name:			
Gender:	Male: ☐ Female: ☐		
Address: Postcode:			
What is your Ethnicity?		What is your first spoken language?	
Do you require an interpreter?	Yes: ☐ No: ☐		
Home Telephone Number:		Mobile Telephone Number:	
E-mail:			
Consent to be contacted by SMS:		Yes: ☐	No: ☐
Consent to be contacted by E-mail:		Yes: ☐	No: ☐
Next of Kin:		Relationship to you:	
Next of Kin contact number:			

SystmOne Enhanced Data Sharing:

Your electronic health record is securely stored using computer software, called SystmOne, which is now used widely across the NHS care organisations. It has the facility to allow information to be shared with other GPs and health professionals, so that everyone in your care is fully informed of you medical history, including medication and allergies. Please choose your sharing options below:

Do you consent for you GP surgery to share your record with other healthcare professionals who an involved in you healthcare?	Do you consent for your GP to see what other healthcare professionals write in your medical record?
Yes ☐ No ☐	Yes ☐ No ☐

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Do you suffer from any allergies? Please list:	

Please tick if you have any of the following conditions:			
Angina	☐	Transient Ischaemic Attack (TIA)	☐
Coronary heart disease	☐	Diabetes	☐
Heart Disease	☐	Asthma	☐
High Blood Pressure	☐	Chronic Obstructive Pulmonary Disease (COPD)	☐
Stroke	☐	Hypothyroidism	☐
Cancer – Please write what type: _____	☐	Kidney Disease	☐
Epilepsy	☐		

Please list any repeat medications that you take, including dosage and frequency. ***(You will need to speak to a clinician before your first prescription can be issued. Please contact reception on 01394 411641 to book a triage call)***	Medication:	Dosage:	Frequency:

The surgery is a dispensing practice (Alderton, Orford & Hollesley sites). If you live more than 1mile (1.6km) from a pharmacy the surgery will now dispense your medications and your pre-set pharmacy will be removed. For all other patients please select a local pharmacy below:

Aldeburgh Pharmacy ☐ Boots Pharmacy - Woodbridge ☐

Leiston Pharmacy ☐ Acer Road – Rendlesham ☐

Saxmundham Pharmacy ☐

All patients (aged 5+) are entitled to a New Patient Check with a Health Care Advisor. Please tick if you would like a New Patient Check:	
Yes ☐	No ☐

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Carer / Cared for:	
Are you an unpaid Family Carer? (A family carer is anyone who is looking after someone who due to illness, mental health, disability, or substance misuse, cannot manage without them)	☐ Yes ☐ No If yes, who do you care for? _____
Would you like to hear from other organisations who support Family Carers?	☐ Yes ☐ No
Does someone look after you?	☐ Yes ☐ No If yes, who cares for you and are they registered with the practice? _____ ☐ Yes ☐ No
Are you housebound? (You are considered housebound if you are unable to leave your home at all, or you require significant assistance to leave your home)	☐ Yes ☐ No

Please complete your smoking status:	
Never Smoked ☐	Vape ☐
Ex-Smoker ☐ Date Stopped:_____	Cigar Smoker ☐ How many_____
Cigarette smoker ☐ How many_____	Roll-ups_____
Would you like help with stopping? ☐ Yes ☐ No	

Patient Participation Group
The Practice is committed to improving the services we provide to our patients. To do this, it is vital we hear from people about their experiences, views and ideas for making services better. By expressing your interest, you will be helping us to plan ways of involving patients that suit you. If you are interested in getting involved, please tick the box below

Patient Signature:	Signature on behalf of Patient:
Relationship to patient:	

Thank you for taking your time to complete this form.