Date:
Staff:

WHITE HORSE SURGERY & WALK IN CENTRE
NEW PATIENT PROFILE FORM

IT IS IMPORTANT THAT YOU COMPLETE AND RETURN THE WHOLE OF THIS FORM AS FAILING TO DO SO WILL DELAY YOUR REGISTRATION

Please complete this form as fully as you can. All information is given voluntarily and is kept in accordance with GDPR. Thank you.

Name: **Address:**	**Date of Birth:** **Telephone Numbers:** **Home -** **Work -** **Mobile -**
Gender : **Male** ☐ **Female** ☐ **Transgender** ☐ **None of the above** ☐	**Next of Kin:** **Name:** **Telephone** **Relationship:**

Are You a Carer?	Yes	No
Do you care for someone who is a patient?	Yes Name of Patient ……..	No
Does somebody care for you?	Yes Name of carer: …….. Phone number: ……....	No
Do you speak and read English?	Yes	No
If English is not your first language, what is your first language?		

If you have any queries when completing this form, please do not leave it blank, but do not hesitate to speak to a member of our staff, who would be happy to assist with any questions you may have.

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Do you need an Interpreter?	Yes Which Language? ……	No

Allergies:

Do you take any regular medication? YES ☐ **NO** ☐

Do you smoke? Yes ☐ **No** ☐

Have you ever smoked? Yes ☐ **No** ☐

Do you drink alcohol? Yes ☐ **No** ☐

Have you ever consumed alcohol? Yes ☐ **No** ☐

Height…….. Weight……..

Ethnic origin: (Please tick one)

British	☐
Mixed British	☐
Irish	☐
Scottish	☐
Welsh	☐
Bangladeshi	☐
Indian	☐
Pakistani	☐
African	☐
Caribbean	☐

Other (please specify) …….

(Please tick one of the following):

Asylum Seeker	☐
Refugee	☐
Homeless Person	☐
Immigrant	☐
Unaccompanied Minor	☐ (under 16)

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Would you be interested in joining our Patient Participation Group?

If so please put your email address here and we will be in contact with details on how you can join.

Do you have a Disability?	Yes Please put which number here_____	No

1.Blind	2.Partially sighted	3.Deaf	4.Hearing impaired	5.Wheelchair Bound
6.Learning Disability	7.Speech Defect	8.Chronic Physical Disability	9.Cerebral Palsy	10.Muscular Dystrophy
11.Epilepsy	12.Motor Neurone Disease	13.Quadriplegia	14.Hemiplegia	15.Paraplegia
16.Mental Illness	17.Dyslexia	18.Multiple Sclerosis	19.Parkinson's Disease	

Last cervical screening date :

PATIENT AUTHORITY - Prescriptions

If you wish for someone else to collect your prescription on your behalf you will have to provide the surgery with written consent. Reception staff will not be able to hand over the prescription to anyone who does not have written consent.

Please complete the appropriate box:

☐ I give consent for …….. (Give person's name) to collect prescriptions on my behalf.

☐ I do not give consent for any third party to collect prescriptions on my behalf.

☐ I wish for prescriptions to be sent direct to Pharmacy **(must complete enclosed Electronic Prescription Service EPS form)**

If you have any queries when completing this form, please do not leave it blank, but do not hesitate to speak to a member of our staff, who would be happy to assist with any questions you may have.

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Date:

Staff:

This consent will remain in force until further notice of cancellation by me.

Signed:……Print Full Name: …….
Date signed: ……../……./……

PATIENT AUTHORITY – Leaving Messages

In accordance with the Data Protection Act, our Surgery requires written consent from any patient who has an answerphone and is happy for our staff to leave a message. If we do not have consent, we will be unable to leave a message on an answerphone or with any third party (i.e. to notify a change or cancellation of an appointment).

Please complete the appropriate box:

☐ I give consent for the Surgery to leave messages and texts on my answerphone for the following number(s):

Telephone Number(s): …….. (give landline or mobile number(s) as appropriate)

☐ I do not give consent for the Surgery to leave any messages on my answerphone or with any third party.

This consent will remain in force until further notice of cancellation by me.

Signed:…… Print Full Name: …….
Date signed: ……../……./ ……

Consent for SMS & Email Communication

SMS communication is operated via a third party provider iPlato, only give consent if you are happy for your details to be shared with them
Working together with iPlato we are able to offer SMS appointment reminders

Email and text messaging are generated using a secure facility, but because they are transmitted over a public network they may not be secure.
Your contact details will be used solely in relation to healthcare services offered by the practice you can choose to opt out at any time by contacting the surgery.

If you have any queries when completing this form, please do not leave it blank, but do not hesitate to speak to a member of our staff, who would be happy to assist with any questions you may have.

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Staff:

Please indicate your consent options below

I consent to SMS & Email communication ☐

Signed …… Print Full Name ……

Date……..

Anonymised Date Collection

White Horse Surgery is part of the THIN (INPS) and as such we send anonymised data extracted by INPS to them , to aid in clinical studies
This is the same company who manage our clinical system and all your clinical data.

Please indicate if you are happy to have your record involved in this process.

Yes ☐

No ☐

Signed…….... Print Full Name……

Date……

If you have any queries when completing this form, please do not leave it blank, but do not hesitate to speak to a member of our staff, who would be happy to assist with any questions you may have.

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Additional Information we may need to know:

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