Hilary Cottage Surgery

We would like to take this opportunity to welcome you to the Practice. We would be grateful if you could take the time to complete the following details.

To register as a patient you will need to provide **photographic identification** (passport, driving licence, visa etc). Your named GP – **Dr Crooke**, will have overall responsibility for the care provided by the Surgery. (Xab9D & XacWQ)

Part of the registration process is for all new patients to have a **New Patient Check** with a Healthcare Assistant. Please book your appointment at Reception.

SURNAME:	**FORENAMES:**	**DATE OF BIRTH:**
Home Telephone No:	Work Telephone No:	Mobile No:
Patient's Mobile Number:	**WE PROVIDE A TEXT REMINDER FOR APPOINTMENTS AND OTHER HEALTH CARE SERVICES. IF YOU DO NOT WANT TO RECEIVE THESE TEXTS PLEASE CIRCLE OPT OUT BELOW.** **OPT OUT (Circle if you wish to Opt Out)**	
Email Address:	**BY PROVIDING YOUR EMAIL YOU ARE GIVING CONSENT FOR US TO EMAIL YOU (y**ou will receive an email asking you to verify the information provided)	

SMOKING *(please circle)*		
Smoker (137R) Cigarettes/Cigars/Pipe N° per day…………….. Would you like smoking cessation advice: **YES** (XaX5W) / **NO** (XaX5X)	**Never Smoked** (XE0oh)	**Ex-Smoker** (Ub1na)

ALLERGIES: Do you have any allergies? If so, what are you allergic to?

LIST YOUR MONTHLY REPEAT MEDICATIONS HERE OR ATTACH REPEAT SLIP:
If you are on any repeat medication please book an appointment to see one of the Doctors **before** your medication runs out and bring your repeat prescription slip to the appointment.

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DISABILITY
Are you registered Disabled *(please circle)* YES / NO
Do you have any communication / information needs relating to a disability, impairment or sensory loss? **If YES, please advise Reception.** ss

CARER INFORMATION	
Are you the main Carer for a sick / disabled child or adult? YES / NO	Do you have a Carer? YES / NO

****IMPORTANT INFORMATION REGARDING MEDICAL RECORD SHARING****

Summary Care Record (SCR) – Please see attached supporting documentation.
You only need to complete the attached form if you wish to Opt Out.
ss

Joining Up Your Information (JUYI) in Gloucestershire – see attached leaflet.
I would like to Opt Out: Yes *(please circle if you would like to Opt Out)*
(XaKRv & XaKRw)

PATIENT SIGNATURE: **DATE:**

THANK YOU FOR COMPLETING THIS FORM

Office use only	**Please circle**	**Documentation Seen & Staff Initials**
Proof of Identification	YES / NO	