**PLEASE RETURN THIS FORM TO RECEPTION AFTER COMPLETION**

# WOODLAWN & OAKLANE MEDICAL CENTRE

## NEW PATIENT INFORMATION - REGISTRATION FORM

**THIS FORM MUST BE COMPLETING IN FULL, FAILURE TO COMPLETE EVERY SECTION COULD RESULT IN A DELAY TO YOUR REGISTRATION.**

**(1)** Patients FULL Name: _____

Date of Birth: _____ NHS No (If Known): _ _ _ _ _ _ _ _ _ _

Address: _____

_____

Telephone Home: _____ Work: _____ Mobile: _____

Email Address: _____

*(EMAIL ADDRESSED MUST BE PERSONAL – DO NOT GIVE SHARED EMAIL ADDRESSES)*

Next of Kin: _____ Relationship: _____

Address Next of Kin: _____

Telephone Next of Kin: _____

Name of School / Childcare Setting: _____

Has this child had any involvement from local authorities: _____

**(2) Patient Consent to Services** – Please read and tick yes or no with your preference to the services our surgery offers its patients.

| | | |
|---|---|---|
| Do you consent to the practice contacting you by text message for the purposes of health promotion and for appointment reminders? (No sensitive information will ever be sent through SMS service) | ☐ Yes | ☐ No |
| Would you like to register for online access? (This will allow you to view your appointments and request repeat medications from your computer/Smartphone) | ☐ Yes | ☐ No |
| Do you consent to share your medical records with authorised healthcare staff like emergency departments so that they are better equipped to treat you safely and effectively? | ☐ Yes | ☐ No |
| Do you consent for this practice to view medical information that you've agreed to share at other NHS care services? | ☐ Yes | ☐ No |

**(3) Information For New/Existing Patients**

The NHS operate a zero tolerance policy with regard to violence and abuse and the practice has the right to remove violent patients from the list with immediate effect in order to safeguard practice staff, patients and other persons. Violence in this context includes actual or threatened physical violence or verbal abuse which leads to fear for a person's safety. In this situation we will notify the patient in writing of their removal from the list and record in the patient's medical records the fact of the removal and the circumstances leading to it.

A Did Not Attend (**DNA**) occurs when an appointment is not attended and the Patient has not contacted the Practice in advance to cancel it or where the cancellation is so late as to make it impossible to allocate that time to another Patient who needs treatment. Our Practice has a **3 DNA** policy, if this happens then you will be removed from the practice and will have to either re-register or find another suitable surgery.

**I agree to the DNA and Zero Tolerance policy**

| Name: | Signature: | Date: |
|---|---|---|
| | | |

**PLEASE NOTE**

**The surgery operates a zero-tolerance policy.**

**Violent or abusive behaviour towards staff will not be tolerated under any circumstances**

**(4) ARE YOU A CARER? Yes / No**

If Yes, Name of person for whom you care: _____

Date of Birth & Address of whom you care: _____

---

**(5) DO YOU HAVE A CARER? Yes / No**

If Yes, Name of person who cares for you: _____

Date of Birth & Address carer: _____

**(6) ETHNIC INFORMATION**

This information is important as certain diseases are more prevalent among people from particular areas of the world. Please tick most appropriate option:

| **Ethnic Category** | | *Write here:* | *Additional Comments:* |
|---|---|---|---|
| WHITE | British, Any other White (please state) | | |
| BLACK/BLACK BRITISH | Caribbean, African, Any other Black | | |
| ASIAN / ASIAN BRITISH | Indian, Pakistani, Bangladeshi, or Other | | |
| MIXED ORIGIN | White & Black Caribbean, White & Black African, White & Asian | | |
| CHINESE | Chinese | | |
| ANY OTHER GROUP | Please State: | | |

**(7) IMMUNINSATION HISTORY** **ONLY For Babies & Children Under 6 Years**

| | **Immunisations** | ***Given (Tick)*** | ***Date Given:*** |
|---|---|---|---|
| 2 Months | - Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenza type b (5 in 10)<br>- #Pneumococcal<br>- Rotavirus | | |
| **3 Months** | - Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenza type b (5 in 10)<br>- Meningitis C<br>- Rotavirus | | |
| **4 Months** | - Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenza type b (5 in 10)<br>#Pneumococcal | | |
| **Between 12-13 Months** | Meningitis C / #4 Haemsssophilus influenza type b (Combined)<br>Measles, Mumps & Rubella<br>- #Pneumococcal | | |
| **Between 3 – 4 Years** | - Measles, Mumps & Rubella<br>- Diphtheria, tetanus, pertussis and polio (4 in 1 – Preschool Booster) | | |

**(8) ADITIONAL INFORMATION:**

To register at Woodlawn & Oaklane Medical Centre we will need you to provide the following:

**Proof of ID:** Passport, Driving License with Photo, or Birth Certificate.

**Proof of Address:** Utility bill, Bank Statement dated within the last 3 calendar months.

**Online Access:** Once you are registered with the practice you can also enrol for our online patient access service which allows you to book appointments, order repeat prescriptions and view certain aspects of your patient record. Please ask at reception for a registration form.