NEW PATIENT REGISTRATION – JUNE 2021

LANGTHORNE HEALTH CENTRE
13 LANGTHORNE ROAD
LONDON
E11 4HX
TELEPHONE NUMBER: 0208 539 2585

L.L. MEDICAL CARE LTD (AGARWAL & AGRAWAL PRACTICE)
Waltham Forest Primary Care Trust

REGISTRATION FORM

This registration form needs to be completed when registering with L.L. Medical Care Ltd. Please complete it as it will help us to process your registration quickly and efficiently.

When registering, you will be asked to produce;

- Your medical card (from GMS1 to be completed if this is not available).
- Photographic proof of identification - driving license, ID card, birth certificate, and proof of address (dated within 3 months)
- If you are registering children under 10 years of age, you must provide copies of all immunisations
- If you have had any previous medication, or have had a change of medication, remember to bring copies of your green form, which is attached to every prescription, on request

As part of your Registration, an appointment will be made to have a "Health Check Appointment) with our Practice Nurse/Healthcare Assistant. Please remember to attend the "Health Check Appointment" at the time and date given as you will not be able to see one of our doctors until your registration has been completed. On the day of your health check a urine sample will be needed.

YOUR CONTACT INFORMATION

MR MRS MS MISS (Please circle as appropriate) Sex: Male ☐ Female ☐

Surname: _____ Forename: _____

Previous Surname: _____

Your NHS Number: ☐☐☐☐☐☐☐☐☐☐

Address: _____

_____

_____

Previous Address: _____

_____

_____

Date of birth: _____/_____/_____

Marital Status: Single ☐ Married ☐ Widow/er ☐
Divorced ☐ Separated ☐ Co-Habiting ☐

If you are from abroad:

Your first UK address where registered with a GP:

_____

_____

_____

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YOUR CONTACT INFORMATION - CONTINUED

If a previous resident of the UK, the date you left the UK _____/_____/_____

If coming from abroad; the date of entry into the UK (This is complusory as we can not register you without this information _____/_____/_____

Home Tel No: _____ Home Tel No: _____

Email Address: _____

Are you a carer? Yes ☐ No ☐

Do you have a carer? Yes ☐ No ☐

YOUR PREVIOUS DOCTOR

Previous Doctors Name and Address: _____

RELIGIOUS BACKGROUND

Religion: None ☐ Christian ☐ Jewish ☐ Sikh ☐
Buddhist ☐ Hindu ☐ Muslim ☐ Other _____

What is your country of origin? _____

If from abroad, please tell us your date of entry into the UK: _____/_____/_____

What is/are your main spoken language/s? _____

Do you need an interpreter? Yes ☐ No ☐

Are you a refugee or an asylum seeker? Yes ☐ No ☐

NHS ORGAN DONOR REGISTRATION

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue maybe used for transplantation after my death, please tick the boxes that apply;

Any of my organs and tissue or ☐

Kidneys ☐ Heart ☐ Cornea ☐ Lungs ☐ Pancreas ☐

Signature confirming my consent to join the NHS Organd Donor Register: _____

Date: _____/_____/_____

NHS BLOOD DONOR REGISTRATION

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years: ☐

Signature confirming my consent to join the NHS Blood Donor Register: _____

Date: _____/_____/_____

My preferred address for donation is (only if different from the above, e.g. your place of work) :

_____

_____

_____

Postcode: _____

All blood types are needed, especially O Negative and B Negative.

Visit www.blood.co.uk or call 0300 123 2323

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MEDICAL HISTORY

Do you have a disability or any special requirements that we may need to take into account?
Yes ☐ No ☐
If yes, please give details: _____
_____

SMOKING

Do you Smoke? Yes ☐ No ☐
If yes, how many a day? _____
If an ex smoker, how long ago did you stop? _____
How many did you smoke daily before giving up? _____

ALCOHOL

Do you drink? Yes ☐ No ☐ If so, how many a day? _____
What do you drink? Beer ☐ Spirits ☐ Wine ☐
Other, please specify _____
Have you ever had your cholesterol checked? Yes ☐ No ☐

CORONAVIRUS (COVID-19)
ABOUT YOU

Have you been in contact with anyone who has contacted COVID-19? Yes ☐ No ☐
When did you contract the virus? ____/____/_____
If you have, have you isolated for the 14 day quarantine period Yes ☐ No ☐
Are you currently shielding? Yes ☐ No ☐

OTHER MEMBERS IN YOUR HOUSEHOLD

How many people live in your household
1-2 ☐ 2-3 ☐ 3-4 ☐ 4 or more ☐
Has anyone else in your household contracted COVID-19? Yes ☐ No ☐
When did he or she contract the virus? ____/____/_____
Have those in your household isolated for the 14 day quarantine period? Yes ☐ No ☐
Is he or she currently shielding? Yes ☐ No ☐

ILLNESSES

Do you suffer from any illnesses? Yes ☐ No ☐

If Yes, please give brief details of illnesses suffered;
_____
_____
_____
_____
_____

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MEDICATION

Please list any prescribed medications that you use below (Please bring your prescribed medication with you when you attend your health check);

_____

_____

IF YOU NEED YOUR DOCTOR TO DISPENSE MEDICINES AND APPLIANCES:

☐ I live more than 1.6km in a straight line from the chemist

☐ I would have serious difficulty in getting them from a chemist

NOT ALL DOCTORS ARE AUTHORISED TO DIPSENSE MEDICINES

NEXT OF KIN

MR MRS MS MISS (Please circle as appropriate) Sex: Male ☐ Female ☐

Surname: _____ Forename: _____

Address: _____

_____

_____

Marital Status: _____

Home Tel No: _____ Mobile No: _____

Relationship to you: _____

PROTECTING YOUR PERSONAL INFORMATION

Do you wish to have a Summary Care Record? Yes ☐ No ☐

I CONSENT TO THE PRACTICE COLLECTING AND STORING MY DATA

Signed: _____ Date: _____/_____/_____

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PATIENT CONTRACT

Dear Patient

We would like to thank you for choosing to register with Our Practice. To enable us to provide you with the best possible service, we ask that you read this form and sign at the bottom of the page.

1. You need to have a Health Check with our Nurse or Healthcare Assistant as part of your Registration. Please ensure you arrive on time. If you are unable to make the appointment please phone and cancel.
2. Our Practice is on the Local and National Screening Programme and patients are asked to keep up-to-date with their Cervical Smears and Children's Immunisations. All patients are responsible for their Health and must ensure they visit the Practice at least once a year to keep their Health Records up to date.
3. Please make sure you provide us with any changes to your address and/or telephone/mobile contact numbers.
4. Our Practice has a "**ZERO TOLERANCE**" policy - We strongly support the NHS policy on zero tolerance. Anyone who attends the surgery and abuses the GP's, staff or other patients be it verbally, physically or in any threatening manner whatsoever, will risk removal from the practice list. In extreme cases we may summon the police to remove offenders from the practice premises.

I, _____ agree to the above terms and conditions.
Signed: _____ (Patient)

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NEW PATIENT HEALTH CHECK FORM

YOUR DETAILS (PLEASE COMPLETE THIS FORM AS ACCURATELY AS POSSIBLE)

Surname: _____ Date of birth: ____/____/_____
Forename: _____
Address: _____
_____
Email Address: _____
Contact Number: _____ Nationality: _____
Occupation: _____
Marital Status: Single ☐ Married ☐ Widow/er ☐
Divorced ☐ Separated ☐ Co-Habiting ☐
Are you a care for a chronically sick relative? Yes ☐ No ☐
If Yes, see Carer's Form)
Present State of Health: Well ☐ Unwell ☐
If unwell, state what is the matter; _____
_____
_____

PAST HEALTH

Please give history of any disease such as;

Diabetes Mellitus	☐	Date: _____
Hypertension	☐	Date: _____
TB	☐	Date: _____
Fits	☐	Date: _____
Jaundice	☐	Date: _____
Stroke	☐	Date: _____
Myorcardial Infarction	☐	Date: _____
Angina	☐	Date: _____
Transient Ischemic attack	☐	Date: _____
Asthma	☐	Date: _____
Other operations	☐	Date: _____

FAMILY HISTORY (1ST RELATIVES) CLOSEST FAMILY/PARENTS/SBLINGS SUFFERING FROM ANY DISEASES LIKE;

Diabetes Mellitus	Yes	☐	No	☐
Hypertension	Yes	☐	No	☐
Sickle Cell/Blood Disorders	Yes	☐	No	☐
Stroke	Yes	☐	No	☐
Coronary Heart Disease	Yes	☐	No	☐
Angina	Yes	☐	No	☐

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DIET AND EXCERCISE

Is your Diet Healthy? ☐ Unhealthy? ☐ I am on a special diet ☐

Do you exercise regularly? Yes ☐ No ☐

SMOKING

Do you Smoke Yes ☐ No ☐

If yes, how many a day? _____

If an ex smoker, how long ago did you stop? _____

How many did you smoke daily before giving up? _____

If you would like to give up smoke, please consult a Doctor

ALCOHOL

Do you drink? Yes ☐ No ☐ If so, how many a day? _____

What do you drink? Beer ☐ Spirits ☐ Wine ☐

Other, please specify _____

Have you ever had your cholesterol checked? Yes ☐ No ☐

WOMEN ONLY

When was your last smear test? _____

Have you had a hysterectomy? Yes ☐ No ☐

Do you use: Pill ☐ Cap ☐ Sheath ☐ Coil ☐

CORONAVIRUS (COVID-19)

ABOUT YOU

Have you been in contact with anyone who has contacted COVID-19? Yes ☐ No ☐

When did you contract the virus? ____/____/_____

If you have, have you isolated for the 14 day quarantine period Yes ☐ No ☐

Are you currently shielding? Yes ☐ No ☐

OTHER MEMBERS IN YOUR HOUSEHOLD

How many people live in your household

1-2 ☐ 2-3 ☐ 3-4 ☐ 4 or more ☐

Has anyone else in your household contracted COVID-19? Yes ☐ No ☐

When did he or she contract the virus? ____/____/_____

Have those in your household isolated for the 14 day quarantine period? Yes ☐ No ☐

Is he or she currently shielding? Yes ☐ No ☐

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NURSES EXAMINATION

ALCOHOL

ALCOHOL, How much? _____ Beer, wines, spirits, other

B/P: ____/_____

BMI: _____ Height _____ Weight _____

Smoking: Yes ☐ No ☐ Ex Cig ☐ Cig ☐ Pipe ☐

What sort of diet: Normal ☐ Diabetic ☐ Low Fat ☐

Low protein ☐ Low Carbohydrate ☐

Low cholesterol ☐ Other ☐

EXERCISE

- ☐ No moderate or vigorous activity of 20 mins duration
- ☐ 1-4 occasions of mixed moderate/vigorous activity
- ☐ 5-11 occasions of mixed moderate/vigorous activity
- ☐ 12 or more occasions of mixed moderate/vigorous activity

CORONARY HEART DISEASE

- ☐ Personal history of heart coronary disease
- ☐ No personal history of heart coronary disease
- ☐ Family history of heart coronary disease
- ☐ No family history of heart coronary disease

CVA/TIA

- ☐ Personal history of Stroke/TIA
- ☐ No personal history of Stroke/TIA
- ☐ Family history of Stroke/TIA
- ☐ No family history of Stroke/TIA

URUNALYSIS

Blood _____

Protein _____

Glucose _____

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REGISTER YOUR TYPE1 OPT-OUT PREFERENCE

The data held in your GP medical records is shared with other healthcare professionals for the purposes of your individual care. It is also shared with other organisations to support health and care planning and research.

If you do not want your personally identifiable patient data to be shared outside of your GP practice for purposes except your own care, you can register an opt-out with your GP practice. This is known as a Type 1 Opt-out.

Type 1 Opt-outs may be discontinued in the future. If this happens then they may be turned into a National Data Opt-out. Your GP practice will tell you if this is going to happen and if you need to do anything. More information about the National Data Opt-out is here: https://www.nhs.uk/your-nhs-data-matters/

You can use this form to:

- register a Type 1 Opt-out, for yourself or for a dependent (if you are the parent or legal guardian of the patient) (to **Opt-out**)
- withdraw an existing Type 1 Opt-out, for yourself or a dependent (if you are the parent or legal guardian of the patient) if you have changed your preference (**Opt-in**)

This decision will not affect individual care and you can change your choice at any time, using this form. This form, once completed, should be sent to your GP practice by email or post.

DETAILS OF THE PATIENT

Title										
Forename(s)										
Surname										
Address										
Phone number										
Date of birth										
NHS Number (if known)										

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DETAILS OF PARENT OR LEGAL GUARDIAN

If you are filling in this form on behalf of a dependent e.g. a child, the GP practice will first check that you have the authority to do so. Please complete the details below:

Name	
Address	
Relationship to patient	

Your decision

☐ **Opt-out**

I do not allow my identifiable patient data to be shared outside of the GP practice for purposes except my own care.

OR

I do not allow the patient above's identifiable patient data to be shared outside of the GP practice for purposes except their own care.

☐ **Withdraw Opt-out (Opt-in)**

I do allow my identifiable patient data to be shared outside of the GP practice for purposes beyond my own care.

OR

I do allow the patient above's identifiable patient data to be shared outside of the GP practice for purposes beyond their own care.

YOUR DECLARATION

I confirm that:

- the information I have given in this form is correct
- I am the parent or legal guardian of the dependent person I am making a choice for set out above (if appliable)

Signature

Date signed

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WHEN COMPLETE, PLEASE POST OR SEND BY EMAIL TO YOUR GP PRACTICE

For GP Practice Use Only

Date received		
Date applied		
Tick to select the codes applied	**Opt – Out - Dissent code:** 9Nu0 (827241000000103 |Dissent from secondary use of general practitioner patient identifiable data (finding)|)	
	Opt – In - Dissent withdrawal code: 9Nu1 (827261000000102 |Dissent withdrawn for secondary use of general practitioner patient identifiable data (finding)|)]	

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