Dear New Patient

***Welcome to the Atrium Health Centre and thank you for choosing to register with us.***

Our surgery exists to administer a good level of medical care to all patients who are registered with the practice and our aim is to provide an effective and helpful service. We offer a variety of special clinics and our website contains details on a number of topics including medical conditions, self-help etc ([**www.atriumhealth.nhs.uk**](http://www.atriumhealth.nhs.uk)**)**. The surgery will liaise on your behalf with hospitals and community care. This information is also available via our practice leaflet (please ask at reception if you would like a leaflet).

As a new patient we would ask that you complete the attached New Patient Questionnaire fully as this provides us with the information to arrange for your medical records to be transferred to us as well as giving us the opportunity to find a little bit about your medical background.All information provided is treated in the strictest confidence and only shared with relevant clinicians and medical staff and is not shared with any third party (unless medically necessary and\or agreed). We will also only contact you via the information you supply only for the purpose of your medical care. Please note registration cannot be processed until the New Patient Questionnaire form is completed in full and is signed and dated.

We operate an appointment system where we will try to offer an appointment with the next available healthcare professional within the next 48hours. We recognise that this can sometimes cause problems for those patients who wish to book appointments with a specific GP; however we feel that this is the best approach under the current nationally directed guidelines. Please remember that if you need to see the doctor on an urgent basis then we will always try to accommodate you, however, do not be offended if the Patient Services Administrator asks you when the problem started and the nature of the problem. They have been instructed to do so by the doctors and it is not meant to be offensive in any way, it just helps us to help you. You are able to pre-book routine appointments with other members of staff i.e. Practice Nurses, Healthcare Assistants, Clinical Pharmacist or other Healthcare staff.

The staff and doctors aim to be helpful, courteous and fair at all times, so please do not hesitate to ask a member of staff for help should the need arise. However, from time to time we may not always get it right and if you are unhappy with the service or have any suggestions for improvements, please do not hesitate to contact me or our Patient Services Manager and we will be pleased to help in any way to resolve the problem.

We do our utmost to provide an excellent service to patients within our financial parameters but, if there is anything that you feel we could be doing better please let us know. We are able to assist patients by escorting them to and from their consultation if appropriate. Patients who are registered hard of hearing are welcome to request appointments via our online service.

Should you wish to register for our online service (and the NHS App) we have to ask that you also provide photographic proof of ID (e.g. passport or a UK photo driving licence) and proof of residency (e.g. current utility bill, recent bank statement or letter from host family/college).

We hope that you will be happy with the service you receive from us and we look forward to a happy patient/practice relationship.

Yours faithfully

Lisa Fall

Business Partner

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Personal Details:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Title | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Surname | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Given Name | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Middle Name(s) | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Known As | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Previous Surname (if applicable) | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Birth | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NHS Number | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Which option best describes how you think of yourself? | | | | Man (including trans man)    Woman (including Trans woman) | | | | | | | | | | | | | | | Non-Binary  in another way (please state) | | | | | | | | | | | | |
| Is your Gender identity the same as the gender you were given at birth? | | | | | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | |
| Which option best describes how you think of yourself? | | | | | Gay or Lesbian    Heterosexual or Straight  I don’t know\not sure | | | | | | | | | | | | | | | Bisexual  in another way (please state) | | | | | | | | | | | |
| **Home Address:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| House Name\Flat No. | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Number & Street | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Locality | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Town | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Postcode | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Preferred Surgery: | | | | Atrium (Dorchester) | | | | | | | | | | | | | | | Crossways | | | | | | | | | | | | |
| **Previous Home Address:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| House Name\Flat No. | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Number & Street | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Town | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Postcode | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Contact Details:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Home Telephone | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Work Telephone | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mobile Telephone | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you consent to us contacting you by text (SMS) | | | | Yes  No  Please tick if preferred communication method | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Email Address | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you consent to us contacting you by email | | | | Yes  No  Please tick if preferred communication method | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Next of Kin Details;** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Next of Kin Name | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Relationship | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Telephone Number | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Please help us trace your previous medical records by providing the following:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name & Address of last GP | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Background Details;** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Town + Country of Birth | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ethnicity | | | | British | | | | | | | | | African | | | | | | Bangladeshi | | | | | | | Caribbean | | | | | |
| Chinese | | | | | | | | | Indian | | | | | | Irish | | | | | | | Other White | | | | | |
| Other Asian | | | | | | | | | Other Black | | | | | | Other Mixed | | | | | | | White Asian | | | | | |
| Pakistani | | | | | | | | | W&B African | | | | | | W&B Caribbean | | | | | | | Refuse to Divulge | | | | | |
| **If you are from Abroad:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of entry into the UK (dd/mm/yyyy) | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Are you a visitor? | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | | | | | | | |
| Are you a UK passport holder? | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | | | | | | | |
| Do you hold an EHIC? (European Health Insurance Card) | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | | | | | | | |
| **If you have worked in the Armed Forces:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Service or Personnel no; | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Enlistment Date | | | |  | | | | | | | | | | | | | | | Date of Leaving | | | | | |  | | | | | | |
| **Communication Needs:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Main Language | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Interpreter Required? | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | | | | |
| Do You have any special Communication Needs? | | | | | | | | | | | | | | | Yes  No | | | | | | | | | | | | | | | | |
| If ‘Yes’ | Sign  Language | | | Large  Print | | | | | | | Other; ………………………………………… | | | | | | | | | | | | | | | | | | | | |
| Accessible Information: If you have stated that you have any special communication needs on this form, we will do our best to accommodate your needs. Should your needs change please inform us. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Carers:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If you are a Carer would you like to be added to the Practice’s register & give consent to receive information | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | No | | | |
| (If yes) I care for (name): | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Relationship to you: | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The person I care for has: | | | | Dementia | | | | | | | Physical Disability | | | | | | | | Mental Illness | | | | | | | | Chronic Disease | | | | |
| **Allergies:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Do you have any Allergies?**  (e.g. antibiotics, food, bee sting, latex) | | | | Yes (Please state); | | | | | | | | | | | | | | | | | | | | | No | | | | | | |
| **Health Information**: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How often do you have a drink containing alcohol? | | | | | | | | | Never | | | | | | Less than Monthly | | | 2 – 3 times a Month | | | | | 2 – 3 times a Week | | | | | | 4 or more times a week | | |
| How many units of alcohol do you drink on a typical day when you are drinking? | | | | | | | | | N\A | | | 1or 2 | | | 3 or 4 | | | 5 or 6 | | | | | 7 or 9 | | | | | | 10 or more | | |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | | | | | | | | | Never | | | | | | Less than Monthly | | | Monthly | | | | | Weekly | | | | | | Daily or almost daily | | |
| **Smoking Status**: (please tick one box only) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I am a Smoker **(For help to stop smoking phone 0800 007 6653 or visit www.nhs.uk/smokefree)**  (including e-cigarettes) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I have never smoked | | | | | | I am an ex-smoker; Date quit: | | | | | | | | | | | | | | | | | | | | | | | | | |
| BP (if known) | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Weight (st\lbs or Kgs) | |  | | | | | | | | | | | | Height  (ft\” or metres) | | | |  | | | | | | | | | | | | | |
| **Are you currently Pregnant?** | | | | | | | | | | | | | | | | | Yes | | | | | | | | No | | | | | | |
| If you are pregnant please provide estimated delivery date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Cervical Smear Monitoring:** Please provide date of last Cervical Smear | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Current Medication**: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **If you have a repeat medication slip from your previous GP please attach to this form.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Electronic Prescription Service:** Under NHS guidelines electronic prescribing is in place and all prescriptions are sent direct to a pharmacy.  **Please let us know the local pharmacy that you will be using;**  **Note;** if this section is left blank we will nominate a local pharmacy for you | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| **Practice Services\Groups**: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Would you be interested in joining the Practice Patient Participation Group? | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | No | |
| **Do you wish to register for online services?** This will enable you to request prescriptions, book appointments, view your summary care record and your medical record. | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | No | |
| **NHS Donor Registration**: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| The NHS Organ Donor and NHS Blood Donor Registers are now an ‘opt out’ system. This means that if you are not in an [excluded group](https://www.organdonation.nhs.uk/uk-laws/organ-donation-law-in-england/#who), and have not confirmed whether you want to be an organ donor (either by recording a decision on the NHS Organ Donor Register , or by speaking to friends and family) it will be considered that you agree to donate your  organs when you die. If you wish to change this or wish to see more information regarding organ donation please visit website; <https://www.organdonation.nhs.uk> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Record Sharing**: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you consent to the sharing of relevant medical information recorded by the practice with any other organisations that may provide medical care to you? | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | No | |
| Do you consent to the practice viewing data that is recorded about by other organisations that may provide medical care to you? (if you have agreed to them sharing your data) | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | No | |
| **Enhanced Summary Care Record**: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do you consent to your **enhanced** medical information to be shared for medical professional to see in the event of you needing care in another part of the country? (i.e. your long-term health conditions, any relevant medical history, your health care preferences, immunisations, Medication and allergies). | | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | No | |
| If you selected ‘no’ your basic details only will be added to the NHS spine (medication, allergies and adverse reactions); if you object to this also being shown please complete the SCR patient consent preference form and return to us; <https://digital.nhs.uk/services/summary-care-records-scr/scr-patient-consent-preference-form> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Other information\Patient Confirmation**: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Declaration:** By providing the information on this form and signing below, you are consenting to be contacted about your medical needs by the practice in accordance with the General Data Protection Regulations via any of the methods you have provided on this form. Also by completing and signing this form you are agreeing to abide by the details in the Atrium Patient Contract and Zero tolerance Policy (copies of which can be found on the practice website or requested from Reception). **If any of the details on this form change in the future it is your responsibility to inform us.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signed: (Patient\on behalf of patient) | | | | | | | | | | | | | | | | | | Date: | | | | | | | | | | | | | |
| **PSA’s when registering patient**: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Registered by (name): | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Patient checked for existing record on SystmOne? | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | | No |
| GP Allocated: | | | | | | | | Yes | | No | | | | | | Patient informed: | | | | | | | | Yes | | | | | | | No |
| Is patient to be registered as Out of Area? | | | | | | | | Yes | | No | | | | | | If yes; Has patient been given out of area letter to sign? | | | | | | | | | | | | | | | |
| **For Online access only** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PIN document for Online access printed\given to patient where applicable | | | | | | | | | | | | | | | | | | | | | | | | Yes | | | | | | No | |
| Type of ID Seen: | | | 1. | | | | | | | | | | | | | | | | | 2. | | | | | | | | | | | |
| Form fully checked & ID Seen by: | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |