heathbridge
PRACTICE

REGISTRATION FORM

PERSONAL INFORMATION

☐ MR ☐ MRS ☐ MISS ☐ MS ☐ DR OTHER: NHS no:_____

SURNAME:	HOME PHONE :
FIRST NAMES:	*MOBILE PHONE:
PREVIOUS SURNAME:	**EMAIL:
DATE OF BIRTH (DD/MM/YYYY):	FIRST LANGUAGE:
ADDRESS:	ETHNICITY:
	TOWN AND COUNTRY OF BIRTH:

***SMS/TEXT:** By providing us your mobile number you consent to receiving health advice and information on your medical records. This is strictly between the practice and patient only. It is your responsiblity to keep and provide an up to date number and understand that the practice is not responsible for onwards use or transmission once it has been received by you. **Please tick here if you wish to OPT IN** ☐

****E-MAIL:** By providing us your email address you consent to receiving health advice and information on your medical records. This is strictly between the practice and patient only. It is your responsiblity to keep and provide an up to date email and understand that the practice is not responsible for onwards use or transmission once it has been received by you. **Please tick here if you wish to OPT IN** ☐

PREVIOUS MEDICAL RECORDS

PREVIOUS ADDRESS IN THE UK:	NAME OF PREVIOUS DOCTOR WHILE AT THAT ADDRESS:
	ADDRESS OF PREVIOUS DOCTOR:

IF YOU ARE FROM ABROAD

YOUR FIRST UK ADDRESS WHERE REGISTERED WITH A GP:

IF PREVIOUSLY RESIDENT IN THE UK, DATE OF LEAVING:	DATE YOU FIRST CAME TO LIVE IN UK:

NOMINATED PHARMACY (Please select one)

HUSBANDS PHARMACY (124 Upper Richmond Rd, SW15 2SP)	☐	PUTNEY PHARMACY (278 Upper Richmond Road, SW15 6TQ)	☐
SMALL BOOTS (109 Putney High St, SW15 1SS)	☐	PAYDENS PHARMACY (266a Upper Richmond Road, SW15 6TQ)	☐
BIG BOOTS (45-53 Putney High St, SW15 1SR)	☐	WALJI CHEMIST (6 Rockingham Close, SW15 5RW)	☐
MOSS BOOTS (383 Upper Richmond Rd, SW15 5QJ)	☐	OTHER:	

EMERGENCY CONTACT

NAME:

RELATIONSHIP:

PHONE:

ADDRESS:

COMMUNICATION NEEDS

DO YOU WEAR GLASSES?

HEARING AIDS?

REQUIRE INTERPRETER?

OTHER INFORMATION

WEIGHT

HEIGHT

BLOOD PRESSURE

WOMEN ONLY

DATE OF LAST CERVICAL SMEAR

RESULT OF LAST CERVICAL SMEAR

MEDICAL INFORMATION

ANY RELEVANT MEDICAL INFORMATION e.g. allergies

ALCOHOL CONSUMPTION

(please use sheet provided)

AUDIT - C SCORE _____

Remanining Audit SCORE _____

SMOKING STATUS

NEVER ☐

EX-SMOKER cigarettes/cigars per day _____ OR _____ Oz tobacco per day

SMOKER cigarettes/cigars per day _____ OR _____ Oz tobacco per day

SUMMARY CARE RECORDS

The NHS would like to share your data with others in a number of ways. Please answer the questions below so that we know how you wish us to share your data. Heathbridge Practice is a part of the national Summary Care Record program. This enables each patient to have a summary of their key medical information held securely on the NHS central database, known as the NHS spine. The summary record can be used in an emergency if you needed treatment when access to the medical record held by your GP was not available; for example if you call the doctor out of hours. You will always be asked to give permission for this record to be viewed and you have the right to decline.

☐ I wish to have a Summary Care Record containing my medications allergies and adverse reactions or sensitivities to medications
☐ I wish to have a Summary Care record with the above plus additional important medical information held on my record
☐ I do not wish to have a Summary Care Record

PATIENT'S SIGNATURE

I hereby declare that the above furnished details are true to the best of my knowledge

Signature _____

Signature on behalf of the patient _____

Date:

Checked by: _____

Patient Online registration form Access to GP online services

Surname			
First name			
Date of birth			
Address			
Postcode			
Email address			
Telephone number		Mobile number	

I wish to have access to the following online services (tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐

Application for online access to my medical record

I wish to access my medical record online and understand and agree with each statement (please tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that it not about me, or is inaccurate I will contact the practice as soon as possible	☐

Signature		Date	

For practice use only

Identity verified through (tick all that apply)	Vouching ☐ Vouching with information in record ☐ Photo ID ☐ Proof of residence ☐	Name of verifier	Date
Name of person who authorised (if applicable)		Date	
NHS number		Practice computer ID number	
Date account created			
Date passphrase sent			
Level of record access enabled	Prospective ☐ Retrospective ☐ All ☐ Limited parts ☐ Contractual minimum ☐		