# Ardmore Medical Centre Patient Registration Form

**PLEASE COMPLETE THE FORM IN BLOCK CAPITALS**

Date of Application: \_\_\_\_\_\_\_\_\_\_\_\_

### Personal Details

|  |  |  |  |
| --- | --- | --- | --- |
| Gender : | Male □ Female □  | Date of Birth |  / / |
| Title : |  |
| Patient forename (s): | (Please underline the name you are known by) |
| Patient Surname : |  |
| Language spoken: |  | Interpreter Required?  | Yes □ No □ |
| Ethnicity: |  | Nationality: |  |
| Occupation: |  | Asylum Seeker / Refugee | Yes □ No □ |

|  |
| --- |
| *If completing the form on behalf of someone* |
| Relationship to patient |  |
| Full name of person completing form for patient |  |
| Signature : |  |

### Contact details

|  |  |
| --- | --- |
| Address: |  |
|  | Post code: |  |
| Contact Numbers: | Preferred 1: |
|  | Preferred 2: |
| I consent to receiving communication from the surgery via text message : Yes □ No: □*(For patients over 16 we operate an Opt Out policy for receiving text messages. Therefore if you do not fill out your preference your consent is assumed. Contact the surgery if you wish to amend this )* |
| For Patients Over 16 we have an Online ServiceThis service is the recommended way to order repeat medications. If you wish to use this service please fill in the next two lines of this form. Once you have been registered, the receptionist will give you the information that will enable you to create a username and password to access the online services |
| Email address: |  |
| I consent to receiving communication from the surgery via email : Yes □ No: □ |

### Staff Use Only

|  |  |  |  |
| --- | --- | --- | --- |
| Patient ID Seen |  | Yes □ No □ | Type of ID: |
| Staff Name |  |  | Date: |

### Medical History

|  |
| --- |
| Have you any of the follow conditions? |
| Asthma/COPD  |  | Epilepsy  |  | Thyroid disease  |  |
| High Blood Pressure  |  | Heart Disease  |  | Cancer  |  |
| Diabetes  |  | Mental Health  |  | Learning Disability |  |
| Substance misuse |  | Other (Please give details) |

### Medical History

|  |  |
| --- | --- |
| Previous GP : |  |
| Previous GP Address: |  |
| Have you any allergies? | No □ Yes □ *(please give details if yes)* |
| Smoking Status | Never smoked □  | Ex- Smoker □  | Smoker □ Amount per day  |
| Alcohol | Do Not Drink Alcohol □  | Drink Alcohol □ approx. units/week |
| Exercise | I do regular exercise □  | I do not do regular exercise □ |
| If Female  | Date of last cervical smear (if you have had) |
|  | If applicable - How many pregnancies have you had? |  |
| Height |  |
| Weight |  |

|  |
| --- |
| Have you any of the follow conditions? |
| Asthma/COPD  |  | Epilepsy  |  | Thyroid disease  |  |
| High Blood Pressure  |  | Heart Disease  |  | Cancer  |  |
| Diabetes  |  | Mental Health  |  | Learning Disability |  |
| Substance misuse |  | Other (Please give details) |

|  |
| --- |
| Medications : Please provide print out of all current medications & immunisation history (from previous GP/ current pharmacy) |
| Drug Name and Strength | Reason taking | Dosage instructions |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

***No medications will be prescribed without prior evidence of prescribing.***

Please note the practice policy is not to prescribe the following drugs unless you provide evidence from your previous GP - this is in the interests of prescribing safety.

* Benzodiazepines: diazepam, temazepam, nitrazepam, lorazepam
* Chlordiazepoxide
* Morphine derivatives: dihydrocoedine, fentanyl, buprenorphine patches, codeine
* Z-drugs: zopiclone, zolpidem

### Private Amber List Medication

Patients who choose to pay privately to see a consultant and are advised that they need an Amber List medication will have to pay for this medication as part of their private treatment. These prescriptions will need to be privately prescribed by the consultant concerned. We cannot make exceptions. See our website for more details.

**Privacy Protection**

Information submitted through this form is used only for the purposes of processing your request. We may be in touch with you in relation to the information submitted.

Our practice has a strict confidentiality policy. This information is not shared with any third party organisations.

**I consent to the practice accessing the NI Electronic Care Record to establish by Health and Care number and clarify my medications if necessary.**

**Patient / Representative’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_\_\_\_\_\_\_\_**