|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| First Name: | Surname: | | **Date of Birth:** | | | **Signed:** |
|  |  | |  | | | Date: |
| Email address: **Mobile Telephone Number: Verified Office use:**  *We will use your mobile number to confirm appointments and to invite you for: Health screening and questionnaires, clinical reviews and routine vaccinations.*  **Do you consent? YES / NO**  *We will also use your mobile number or email address to send newsletters, health event invites and PPG’s minutes of meeting and newsletters.*  **Do you consent? YES / NO**  *Your contact details will remain confidential and are not shared with anyone else and you can opt out of receiving texts and emails at any time.* | | | | | | |
| **Occupation:** | | | **First language spoken:** | | | |
| **Ethnic Origin:** | | | | | | |
| **Are you a carer:**  **YES / NO** | | **To Whom:**  **Relationship:** | | | **Next of Kin:** | |
| **Do you have a Carer:**  **YES / NO** | | **Who cares for you:**  **Relationship:** | | | | |
| **FOR UNDER 18s ONLY**  **Parent/Guardian Name:** | | |  | | | |
| **School:** | | | | **Start Date:** | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Are you pregnant?** | YES / NO | | **Estimated Date of Delivery:** | | | |  | |
| **Have you ever been a smoker?** | | YES / NO | | |  | | | | |
| **If you are an ex-smoker when did you give up?** | | | |  | |  | | | |
| We encourage all our smokers to stop smoking. Please ask at reception if you would like an appointment with our AP for Smoking Cessation. | | | | | | | | | |
| **How many glasses of wine/spirits or pints of lager/beer do you drink in an average week?** | | | | | | | |  |
| Occasional drinker / Teetotal (please circle) | | | | | | | | | |
| **Tell us about any disabilities or communication needs that you may have** | | | | | | | | |
| **Do you suffer from any allergies/sensitivities?** | | | | | | | | |

**Application for Online Services**

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Landline number | Mobile number |

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

|  |  |
| --- | --- |
| 1. Booking appointments | **☐** |
| 2. Requesting repeat prescriptions | **☐** |
| 3. Accessing my medical record | **☐** |

I wish to access my medical record online and understand and agree with each statement (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. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible | **☐** |
| 5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible | **☐** |
| 6. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible. | **☐** |

|  |  |
| --- | --- |
| Signature | Date |

# For practice use only

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient NHS number | | | Practice computer ID number | |
| Identity and Mobile number verified by (initials) | Date | | Method | |
| Vouching | **☐** |
| Vouching with information in record | **☐** |
| Photo ID | **☐** |
| Authorised by | | | Date | |
| Date account created | | | | |
| Date passphrase sent | | | | |
| Level of record access enabled | | | Notes / explanation | |
| All | | **☐** |
| Prospective | | **☐** |
| Retrospective | | **☐** |
| Detailed Coded Record | | **☐** |
| Limited Parts | | **☐** |