|  |  |  |  |
| --- | --- | --- | --- |
| 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 | **☐** |