QUARRYSIDE MEDICAL PRACTICE

PATIENT REGISTRATION

12 years of age and over

Personal Information

Quarryside Medical Practice collects and holds your personal information in compliance with the General Data Protection Regulation (2018). For more information, please refer to our Data Policy held on our website and clinic notice board.

First Name(s):	**Surname:**
Date of Birth:	❑ **Male** ❑ **Female**
Flat no/House name:	**Street Name:**
Town:	**Postcode:**
Mobile phone No:	**Home/work No:**
E-mail address:	**Country of Birth:**
Is a Translator required? ❑ **Yes** ❑ **No**	**Languages spoken:**

Optional: **Next of Kin/Emergency Contact:**

Full name: .... **Relationship:** ....

Mobile phone No: .... **Home/Work No:** ....

** Where you have provided us with the name and personal data of an individual, it is your responsibility to ensure that the individual is aware and accepts the terms of the Practice Privacy Policy on our website. If they have any objection, please contact our Data Privacy Officer on: j.dagianti@nhs.net*

Medical Information *(new patients only)*

Allergies :

Do you have any known allergies? ❑ **Yes** ❑ **No** **If yes, please provide details –**

....

Smoking :

Do you Smoke? ❑ **Yes** ❑ **No** **If yes, how many per day?** ....

Are you an ex smoker? ❑ **Yes** ❑ **No** **If yes, when did you stop?** ....

Alcohol :

Do you drink? ❑ **Yes** ❑ **No** **If yes, how much per week?** ....

Conditions :

Do you suffer from any of the following - if yes, please tick:

❑ **Diabetes** ❑ **Heart Disease** ❑ **Stroke** ❑ **High Blood Pressure** ❑ **Asthma** ❑ **COPD**

Please list any other medical conditions? ....

Consent *(All patients)*

During the course of your care, we may send reminders of your appointments, notification regarding Flu clinics, surgery closures and other matters. We may share your contact information with other Healthcare professionals, social care staff, organisations and administrators involved in your care.

Please tick to 'opt-in' or 'opt-out' of the following

(please note, you can opt-out at any time by notifying our Data Privacy officer – please ask reception for details)

I consent for the practice to communicate with me by phone *(including SMS messages and voicemail messages)* in relation to my healthcare -	☐ **Yes** ☐ **No**
I consent for the practice to communicate with me by e-mail in relation to my healthcare –	☐ **Yes** ☐ **No**
I consent for the practice to communicate with me by post in relation to my healthcare -	☐ **Yes** ☐ **No**
I confirm that I authorise the named person(s) to collect my medical prescriptions, sick notes and documentation on my behalf -	**Full Name(s):**
Please note: parents cannot access the medical records of their children, aged 12 and over, without their consent. **I confirm that I authorise the named person(s) to communicate with the practice on my behalf regarding my appointments, results, and any other information in relation to my health care.**	**Full Name(s):**
I consent for the named local pharmacy to collect my prescriptions on my behalf -	**Pharmacy Name:** **Location:**

By registering with the practice, you consent to your medical history from your previous practice(s) being sent to Quarryside Medical Practice. The provision of this information is essential in order that we can deliver personal care and medical treatment.

You have the right to object to information being shared for your own care, and the right to have any mistakes or errors corrected. Please ask reception to speak to the Data Privacy Officer.

Patient name (block capitals): ....

Patient Signature: .... **Date:** ....