Dear New Patient

Welcome to the Atrium Health Centre and thank you for choosing to register with us.

Our surgery exists to administer a good level of medical care to all patients who are registered with the practice and our aim is to provide an effective and helpful service. We offer a variety of special clinics and we stock leaflets and booklets on a number of topics including medical conditions, self-help etc. The surgery will liaise on your behalf with hospitals and community care. This information is also available via our website – **www.atriumhealth.nhs.uk** and our practice leaflet (please ask at reception if you would like a leaflet)

As a new patient we would ask that you complete the New Patient Questionnaire below fully as this provides us with the information to arrange for your medical records to be transferred to us as well as giving us the opportunity to find a little bit about your medical background. **You must also provide photographic proof of ID (e.g. passport or a UK photo driving licence) and proof of residency (e.g. current utility bill, recent bank statement or letter from host family/college). Please note your registration cannot be accepted until the forms are completed in full, with all requested details and proof of ID and residency can be confirmed.**
All information provided is treated in the strictest confidence and only shared with relevant clinicians and medical staff.

We operate an appointment system where we will try to offer an appointment with the next available healthcare professional within the next 48hours. We recognise that this can sometimes cause problems for those patients who wish to book appointments with a specific GP; however we feel that this is the best approach under the current nationally directed guidelines. Please remember that if you need to see the doctor on an urgent basis then we will always try to accommodate you, however do not be offended if the Receptionist asks you when the problem started and the nature of the problem. They have been instructed to do so by the doctors and it is not meant to be offensive in any way, it just helps us to help you. You are able to pre-book routine appointments with other members of staff i.e. Practice Nurses and Healthcare Assistants.

The staff and doctors aim to be helpful, courteous and fair at all times, so please do not hesitate to ask a member of staff for help should the need arise. However, from time to time we may not always get it right and if you are unhappy with the service or have any suggestions for improvements, please do not hesitate to contact me or either our Practice Manager or Reception Lead and we will be pleased to help in any way to resolve the problem.

We do our utmost to provide an excellent service to patients within our financial parameters but, if there is anything that you feel we could be doing better please let us know. We are able to assist patients by escorting them to and from their consultation if appropriate. Patients who are registered hard of hearing are welcome to request appointments via our online service or fax machine.

We hope that you will be happy with the service you receive from us and we look forward to a happy patient/practice relationship.

Yours faithfully

Lisa Fall
Practice Business Manager

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Old Farm Way Crossways Dorchester DT2 8TU
T: 01305 854355 F: 01305 854492

Dr Stephan Johannes
BSc (Hons) MBBS
DRCOG DFFP

Dr Sian Griffiths
BM DRCOG

Dr Andrew Allen
MB ChB MRCGP DCH

Dr Laura Morgan
BM MRCGP

Dr Walid Ahmed
MB BCH MRCP
MRCGP

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COMMUNICATION NEEDS:

Do You have any special Communication Needs?	☐ Yes	☐ No

If 'Yes'	☐ Sign Language	☐ Large Print	☐ Other; ....

Accessible Information: If you have stated that you have any special communication needs on this form we will do our best to accommodate your needs. Should your needs change please inform us.

PERSONAL DETAILS:

Title	
Surname	
Given Name	
Middle Name(s)	
Known As	
Previous Surname (where applicable)	
Date of Birth	
NHS Number	
Gender	☐ Male ☐ Female
Town + Country of Birth	
Marital Status	
Ethnicity	☐ British ☐ African ☐ Bangladeshi ☐ Caribbean ☐ Chinese ☐ Indian ☐ Irish ☐ Other White ☐ Other Asian ☐ Other Black ☐ Other Mixed ☐ White Asian ☐ Pakistani ☐ W&B African ☐ W&B Caribbean ☐ Refuse to Divulge
Main Language	
Interpreter Required?	☐ Yes ☐ No

HOME ADDRESS:

House Name\Flat No.	
Number & Street	
Locality	
Town	
Postcode	

CONTACT DETAILS:

Home Telephone	
Work Telephone	
Mobile Telephone	
Email Address	

PATIENT CONTACTS:

Next of Kin	
Relationship	
Telephone Number	

PLEASE HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING:

Previous address in the UK	
Name & Address of last GP	
Where were you last treated?	(e.g. GP surgery, walk-in centre, A&E etc)

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If you are from Abroad:	
First UK address where registered with a GP	
If previously resident in UK date of leaving;	
Date you first came to live in the UK	

If you are returning from the Armed Forces:			
Address before enlisting			
Service or Personnel no;			
Enlistment Date		Date of Leaving	

Carers Group:

If you are a Carer would you like to be added to the Practice's register to receive regular information and meeting dates ☐ Yes ☐ No

(If yes) I care for (name):

Relationship to you:

The person I care for has: ☐ Dementia ☐ Physical Disability ☐ Mental Illness ☐ Chronic Disease

Medical History:

Please tick all current or past illnesses/operations including dates where possible:

☐ Heart Disease / Angina	☐ Diabetes	☐ Epilepsy
☐ High Blood Pressure	☐ Stroke/TIA	☐ COPD
☐ Asthma	☐ Cancer	☐ Hypothyroidism
☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Dementia
☐ High Cholesterol	☐ Other (please state):	

Do you have any Allergies? ☐ Yes - Please state: ☐ No
(e.g. antibiotics, food, bee sting, latex)

Immunisations; If known, please circle the immunisation received and complete the date if known;

	Date Received		Date Received
☐ Pneumococcal		☐ Polio	
☐ Tetanus		☐ Yellow Fever	
☐ Typhoid		☐ Hepatitis B	
☐ Hepatitis A		☐ MMR	

Ladies: Are you currently Pregnant? ☐ Yes ☐ No

If you are pregnant please provide estimated delivery date:

Health Information:

Weight (st\lbs or Kgs)		Height (ft\" or metres)	

Smoking Status: (please tick one box only)

☐ I am a Smoker

(For help to stop smoking phone 0800 007 6653 or visit ww.nhs.uk/smokefree)

☐ I have never smoked ☐ I am an ex-smoker - Date quit:

Drinking:
Number of Alcohol units consumed per week;

Please complete the following questions;
(Alcohol 'FAST' screening test) **Screening test declined** ☐

Scoring:	0	1	2	3	4	Total
How often do you have 8 (Men) or 6 (Women) or more drinks one occasion?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	

Only answer the following 3 questions on the next page if your score above is 2,3 or 4:

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Scoring:	0	1	2	3	4	Total
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
Has a relative/friend/clinician been concerned about your drinking/advised you to cut down?	Never	Less than Monthly	Monthly	Weekly	Daily or almost daily	
					Total	

CURRENT MEDICATION:

If you have a repeat medication slip from your previous GP please attach to this form.

Electronic Prescription Service: The practice can send your prescription to your pharmacy electronically. If you previously nominated a pharmacy in another area and you now wish to change to a local pharmacy, please inform us of your new preferred pharmacy:	

PRACTICE SERVICES\GROUPS:

Would you be interested in joining the Practice Patient Participation Group?	☐ YES	☐ NO
Do you wish to register for online services? (Online prescriptions, appointment booking, view summary care record)	☐ YES	☐ NO

OTHER INFORMATION\PATIENT CONFIRMATION:

Declaration: In accordance with the Data Protection Act, the Practice needs consent from any Patient for us to leave a message, send a text or information regarding their medical treatment. By providing the information on this form and signing below, you are consenting to be contacted about your medical needs by the practice as well as sharing your enhanced summary care record for other medical professionals and related staff (a leaflet is available about enhanced record sharing – please ask at reception if you would like a copy or visit our website).
Also by completing and signing this form you are agreeing to abide by the details in the Atrium Patient Contract and Zero tolerance Policy (copies of which can be found on the practice website or requested from Reception).
If any of the details on this form change in the future it is your responsibility to inform us.

IF YOU ARE REGISTERING A CHILD UNDER THE AGE OF 5:

☐ I wish the child above to be registered with the doctor named below for Child Health Surveillance

Signed: (Patient\on behalf of patient)	Date:

NHS DONOR REGISTRATION:

I wish to register my details on the NHS Organ donor\the NHs Blood Donor register(s) as someone whose organs \tissue may be used for transplantation after my death &\or who may be contacted and would be prepared to give blood. For more information visit www.uktransplant.org.uk. I would like to donate: (Please tick all boxes that apply)

☐ Any of my organs & tissue **or;**	☐ Any part of my body **or;**	
☐ Heart only	☐ Liver only	☐ Corneas only
☐ Kidneys only	☐ Lungs only	☐ Pancreas only

I would like to join the Blood donor register;	☐ Yes	☐ No
I have given Blood in the last 3 years;	☐ Yes	☐ No
Signature confirming consent\ agreement of items ticked above;		

RECEPTION ONLY (WHEN ACCEPTING FORM):

Type of ID Seen:	1.	2.
Form fully checked & ID Seen by:		

WHEN REGISTERING PATIENT:

EMIS no checked	☐ YES	☐ NO	Registered by (name):		
GP Allocated:	☐ YES	☐ NO	Patient informed:	☐ YES	☐ NO
PIN document for Online access printed\given to patient where applicable				☐ YES	☐ NO