Maples Medical Centre
2 Scout Drive
Newall Green
Manchester
M23 2SY
0161 498 8484
www.maplesmc.co.uk

Lakes Medical Centre
53c Mainwood Road
Timperley
Altrincham
WA15 7JW
0161 980 4510
www.lakesmc.co.uk

Thank you for registering to be a Patient at the Maples/Lakes Medical Centre.

Firstly, before completing this form may we ask you to check with the receptionist or use this link https://www.nhs.uk/Service-Search/GP/LocationSearch/4 to find your nearest GP Practice as you may fall out of our catchment area.

To complete your registration, the practice will require s the following (one must show your address, the other photo identification (I.D.). These must be from the following lists: -

Your identification - * Photo ID (1 from this list)

- Passport*
- Driving Licence*
- Your National Health Service number

Paper ID (not copies) (1 from this list)

- Utility bill** must be dated within the last 3 months
- Bank Statement** showing your latest address, must be dated within the last 3 months;
- Government letter dated within the last 3 months.
- Full Birth certificate (A4 size).
- Your P45/P60.

** We need this documentation to confirm your address. However, if you do have any utility bills and or bank statement, you must either: -

- Supply a letter from the bill payer that resides at the same address as you; or if you are subletting, a letter from the Council/Housing Association/Private Landlord. This letter must state your name, the address where you live, date of occupation, and must be signed by both parties.
- A letter or official tenancy agreement from the Council, Housing Association or Private Landlord – which must state your name, the address, date of occupation and must be signed.

PLEASE NOTE IF THE ABOVE INFORMATION IS NOT SUPPLIED WITHIN 2 WEEKS YOUR PENDING APPLICATION WILL BE DESTROYED.

Should you have difficulty in supplying any of the above please let our receptionists know to discuss further.

The Maples/Lakes Medical Centre

New Patient Registration Form

The Maples & Lakes Medical Centre

OFFICE USE ONLY:

Date Received:		Pt allocated GP:	9NN60
Received by:		Pt informed of GP:	67DJ
NPHC Booked:		Codes:	
Input by:		Pt summary obtained:	

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in **BLOCK CAPITALS** and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Please complete a separate form for each family member to be registered.

Surname:	
Forename:	

Mr / Mrs / Miss / Ms / Mx Other……..	**NHS number if known:**
Address (please state the area where you actually reside) **House number or name:**	Mobile number:
Street:	Work Number:
Area:	Home Number:
Town:	E-mail Address:
Post code:	Next of kin contact number: Name of next of kin:

Date of Birth:	Previous Surname (s) :	Country and Town of Birth:

Marital Status:		Gender: (please tick ✓)	Him	Her	If applicable, please state the date you first came to live in Britain? **Date:** / /

Your Previous address and postcode:

Previous Doctors name & address and telephone number **(this must be supplied in order for us to contact them on your behalf and you have given your consent to contact them by doing so)** – please allow us permission to do so Yes ☐ No ☐

Surgery Name:	
Address:	
Contact number:	

Other residents of your home:

Name	Age

Names and ages of children		**School/College/University if studying:**
Name	Age	

If returning from Armed Forces(delete accordingly): Army, Navy, Royal Air Force	Your Service or Personnel Number	Your Enlistment Date

Your Religion (Please tick ✔)	C of E	Catholic	Other Christian (state)	Buddhist	Hindu	Muslim
	Sikh	Jewish	Jehovah's Witness	No religion	Other religion (state)	

Your Ethnic Origin: (Please tick ✔)	White (UK) 9i0	White (Irish) 9i1%	White (Other) 9i2%
Caribbean 9i3	African 9i4	Asian 9i5	Other Mixed Background 9i6%
Indian / Brit Indian 9i7	Pakistani / Brit Pakistani 9i8	Bangladeshi / Brit Bangladeshi 9i9	Other Asian Background 9iA%
Other Black Background	Chinese 9iE	Other 9iF%	Ethnic Category not stated 9iG

Your main or 1st language spoken / understood: (Please tick ✔)		English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi
Polish	Ukrainian	French	German	Spanish	Other: (Please Specify)		

Smoking, Alcohol Consumption and Exercise:

Are you currently a smoker?	Yes ☐	No ☐	Have you ever been a smoker?	Yes ☐	No ☐
If so, how many cigarettes / cigars / tobacco do you smoke in a week?			How much alcohol do you drink in a week (Units)? **(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)**		
If you are a smoker and want to stop, please ask for information about local smoking cessation services.					
How often do you exercise?	No. times per week:		Type(s) of exercise:		

Your height:	Feet / inches	Cm	Your weight	Stones / lbs.	kg

Your Medical Background:

What illnesses have you had, and when?	
What operations have you had, and when?	
Do you have any medical problems at present?	
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)	

Are you able to administer your own medicines?	Yes	No	If no – please detail specific issues (e.g. swallowing, opening containers)

Are there any serious diseases that affect your Parents, Brothers or Sisters (tick ✓ all that apply)	Diabetes	Heart Attack	Heart attack under age of 60	Bowel Cancer	
	Breast Cancer		High Blood Pressure	Asthma	Stroke
	Thyroid Disorder		Any other important Family Illness?		

What immunisations have you had? (Please tick ✓ all that apply)	Diphtheria	Measles	German Measles	Tetanus	Polio	MMR
	Whooping Cough		Pre-school booster	Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses		

Specific Needs: Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:	
Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):	
Do you require correspondence to be in Braille, Large Print or Audio Tape:	
Are you an 'Assistance Dog' User?	
Please state any Physical disabilities you have:	
Please state any Mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises	
Please state any Religious or Cultural needs:	
Do you require the help of a Translator / Interpreter?	
Please state any specific nutritional requirements you have:	
Please state any allergies and sensitivities you have:	
Please state any phobias you have:	
If you are a Carer, please state the name / address / phone number of the person you care for:	**Person Cared For Contact Details:**

If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.		Carer Contact Details:
		Signed: Date:
Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	Yes / No	If "Yes", can you please bring a written copy of it to your New Patient Consultation?
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	Yes / No	If **"Yes",** please state their name / address / phone number:

Women only:				
When was your last smear done?	Date:	Was this at your GP's Surgery?	Yes	NO
What was the result of the smear?				
Date of last mammogram (if applicable):	Date:	Method of contraception (if used):		
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?			Yes	NO

Summary Care Records.
The NHS is changing the way your health information is stored and managed.
The NHS Summary Care record is an electronic record of important information about your health.
It will be available to health care staff providing your NHS Care. An information pack has been provided.

Are you happy to have a Summary Care Record?	Yes	No	More Time Required to decide: (please tick ✔)

Patient Signature:		Signature on behalf of Patient:	
Date:		Date:	

To opt in for the practice to contact you via email, letter, phone and text, please tick the box opposite. **(Please circle yes or no)**	Phone/text	**Yes** 9NdP	**No** 9NdQ
	Results	**Yes** 9NdP0	**No** 9NdQ0
	Email:	**Yes** **9Nds**	**No** 9Ndy
Would you like us to register you to use our on-line system, which allows you to order repeat prescriptions and make appointments?	☐	Please tick if yes	

Patient Participation Group:

The Practice is committed to improving the services we provide to our patients.
To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.
By expressing your interest, you will be helping us to plan ways of involving patients that suit you.
It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.
If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.

Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the box opposite)	☐

Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).

The Consultation will also establish relevant past medical and family history, including:

- Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health
- Social factors - employment, housing, family circumstances
- Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.

We may also have to share your information, subject to strict agreements on how it will be used, with the following organisations or receive information from the following organisations:-

- NHS Trusts / Foundation Trusts
- GP's
- NHS Commissioning Support Units
- Independent Contractors such as dentists, opticians, pharmacists
- Private Sector Providers
- Voluntary Sector Providers
- Ambulance Trusts
- Clinical Commissioning Groups
- Social Care Services
- NHS Digital
- Local Authorities
- Education Services
- Fire and Rescue Services
- Police & Judicial Services
- Other 'data processors' which you will be informed of

You will be informed who your data will be shared with and in some cases asked for explicit consent for this happen when this is required.

We may also use external companies to process personal information, such as for archiving purposes. These companies are bound by contractual agreements to ensure information is kept confidential and secure.

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or see our website: www.maplesmc.co.uk