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 **www.nhs.uk/Service-Search/GP/LocationSearch/4** to find your nearest GP Practice as you may fall out of our catchment area?

It is important that you provide your ***National Health Service (NHS) number** if you have been given one**,** and full details i.e. name and address of your previous GP**.**
If you were not born in England, you must state the date you entered the Country.

To complete your registration the practice will require the following (1 ID must show your address, the other photo identification (I.D.)). These must be from the lists below: -

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

- Driving Licence* and or Passport*

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);
- Full Birth Certificate (A4 size).
- Your P45/P60.
- Government letter dated within the last 3 months.

** 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 **all** 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.**

*As a new patient to our practice you are obliged to attend a New Patient Health Check **within 3 weeks of registering**. A New Patient Health Check will be sent to you if we are unable to make you one on the day**. Please note that it is imperative that you attend this appointment.***

For your information only – it can take up to two weeks to process your registration form so you may not automatically get a GP appointment on the same day of registering. Also, please note if the above information is not provided within 2 weeks you application will be destroyed.

Additionally, should you have difficulty in supplying any of the documents, or if you wish to discuss the above in more detail please speak to our Receptionists.

New Patient Registration Form
The Maples & Lakes Medical Centre

OFFICE USE ONLY:

Date Received:	Pt allocated GP code 9NN60 input:
Received by:	Pt informed of GP code 67DJ input:
NPHC Booked:	All Coding input:
HB – needs visit?:	Care home code: V0
Input by:	Pt summary obtained:

Please complete this confidential form (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 (where relevant)

Surname:	
Previous Surname (s) :	
Forename:	

Mr / Mrs / Miss / Ms / Mx Other……..	***** NHS number:**
Date of Birth:	If applicable, please state the date you first came to live in Britain? **Date:** / /
Address (please state the area where you actually reside) **House number or name:**	Country and Town of Birth: Mobile number:
Street:	Home Number:
Area:	work Number: Other contact number:
Town:	E-mail Address:
Post code:	Next of kin contact number:
Care home / Nursing home - Please tick if yes: ☐	Name of next of kin:

Marital Status:		Gender:	Her:	Him:	Other: Please state:	

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

Name	Age

School/College/University if studying:

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)		
Do you require the help of a Translator / Interpreter? Office – put in the code for the chosen language			No ☐	Yes ☐	If yes, please let us know which language?		

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 state any physical disabilities you have:	

Please state any mental disabilities you have:			
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)			
Please state any phobias you have:			
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:	
Are you considered housebound? Office – put in the code 13CA if yes.	
Please state any Sensory Impairment you have (e.g.. 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 requirements you have to be able to access the Practice premises	
Please state any religious or cultural needs:	
Please state any specific nutritional requirements you have:	
Please state any allergies and sensitivities 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, and or **anyone else**)?	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 app)	Date:	Method of contraception (if app)		
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?			Yes	No

Summary Care Records (SCR).

The NHS Summary Care record is an electronic record of important information about your health.

Access to SCR information means that care in other settings is safer, reducing the risk of prescribing errors. It also helps avoid delays to urgent care.

At a minimum, the SCR holds important information about;

- current medication
- allergies and details of any previous bad reactions to medicines
- the name, address, date of birth and NHS number of the patient

Please confirm your preferences for your summary care records by ticking one box below: -

Consent given for medication, allergies, and adverse reactions **ONLY**	☐	(**9Ndm)**
Consent given for medication, allergies, adverse reactions, **AND** additional information e.g long-term conditions	☐	**(9Ndn)**
You do not want a summary care record	☐	

To opt out from this practice sharing your information with a 3rd party e.g. research body, please tick the box opposite.	☐

Please circle yes or no, **to opt in** on how you wish to be contacted by the practice.	Phone/text	**Yes** 9NdP	**No** 9NdQ
	For Results by text/phone	**Yes** 9NdP0	**No** 9NdQ0
	Email:	**Yes** **9Nds**	**No** 9Ndy
Please let us know your preferred method of contact: (please circle)	Letter Phone Text Email ***Office: 8CN2.***		

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

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

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.	☐	(9NS9)

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.

For more information about the services we offer
or see our website: www.maplesmc.co.uk / www.lakesmc.co.uk

Would you like us to register you to use our on-line system, which allows you to order repeat prescriptions and make appointments? If yes, please complete Patient Access form attached.

The Lakes Medical Centre I The Maples Medical Centre

PATIENT/PROXY ONLINE ACCESS

Did you know that you can now book telephone consultations with a GP, request repeat medications, check your symptoms, see what immunisations you have had, and or check your allergies/adverse reactions, on-line.

You can still contact us by phone or call into the surgery for these services. However, being able to see your records on-line might help you to manage your medical condition (s) as you can access this information at any time/anywhere.

Please complete this form if you would like on-line access.

CONSENT FORM FOR ONE PATIENT

Please tick **one** of the following boxes:-

- I am a patient, and I would like to be able to use patient online access. ☐
- I would like proxy access for the patient opposite as a carer. ☐
- I would like proxy access for the patient opposite as a parent/guardian. ☐

Information for Patient Access: -

- Once this form is actioned, and you have indicated what you as a patient would like access to, you will be able to book appointments, order repeat prescriptions. If you request hospital letters, a GP will need to authorise this part of your request.
- You must show photo ID and proof of your address at the time of requesting access.

Declaration for On-line Patient Access: -

- I agree to inform the surgery as soon as possible of any problems/errors I see whilst using the system.
- I reserve the right to change any decision I make in granting me access at any time.
- I understand the risks of allowing someone else to have access to my health records.
- I adhere to use this system in accordance with all instructions given.

Information on Proxy Access: -

- The representative, parent or guardian must show their photo ID, proof of their address, and proof of parental right e.g. birth certificate if a child (if applicable), at the time of requesting proxy access for the patient.
- If there are any limitations on access to a patient and or their information imposed by Court or Children's /Adult Services, it must be declared beforehand.
- One parent, with parental rights, may request proxy access for their child under the age of 11.
- If you are applying on behalf of a child, once the child turns 11 years of age their online services registration will expire, and a new request will need to be completed.
- Young people under 16 years are sometimes deemed competent to make important decisions themselves. The surgery will take this into account if the young person does not wish to grant access to their medical records to a parent/guardian.
- Anyone over 16 years is presumed to have consent to access their online medical records.
- If the patient does not have capacity to consent to grant proxy access, the surgery will consider the request carefully to ensure that it is the best interest of the patient.
- The representative/parent or guardian with proxy access will be able to book appointments, order repeat prescriptions for the patient, and will also have access to the elements of the patients record that have been released by the GP for online access.

On-line Proxy Access Declaration: -

I understand my responsibility for safeguarding sensitive medical information; and I understand and agree with each of the following statements:

- I agree that I will treat the patient's information as confidential.
- I will be responsible for the security of all the patients' information.
- I will contact the surgery as soon as possible if I suspect that the account has been accessed by someone without my agreement.
- If I see information in the record that is not about the patient, or is inaccurate, I will contact the Surgery as soon as possible.

PLEASE COMPLETE ALL RELEVANT INFORMATION BELOW:-

Name of Patient:	
Date of Birth:	
Main contact number:	
Email address – please print	

Please tick what you would like on-line access to; if you are unsure please speak to a receptionist.

Medications ☐	Patient hospital letters ☐
Book a GP telephone appointment ☐	Test results ☐
Immunisation ☐	Allergies ☐
On-line symptoms checker ☐	

Please tick this box to confirm that you have read and agree with the information on the opposite page. ☐

Signed by the patient:	**Dated:**

On-line Proxy Access

If on-line access is to being applied by someone else other than patient please provide their details below:-

Full name of the person (representative) to be given online access to the Patients Medical Records:	
Date of birth:	
Contact number:	
Address:	
Email address (please print address):	
Relationship to patient:	

As a proxy for the patient, I wish to have online access to the services ticked in the boxes above, for the above-mentioned patient; and confirm that I have read and agree with the information on the opposite page. Please tick to agree ☐

Signed by the representative:	**Dated:**

All information is kept in the strictest of confidence, and in line with GDPR.

For Surgery use only - please tick and where applicable state what proof you have seen for the Patient			
EMIS number:		NHS number	
Vouching with info in record		Identity verified by (initials)	
Photo ID		Proxy access authorised by	
Proof of residence		Level of record access enabled	
Personal Vouching		Date granting from	

Please tick and where applicable state what proof you have seen for the Parent/Guardian/Representative			
Vouching with info in record		Personal Vouching	
Photo ID		Identity verified by (initials)	
Proof of residence			

Office: Please scan this form to medical records