Greens Norton & Weedon
Medical Practice
Weedon Surgery: 57 New Croft, Weedon, Northampton NN7 4RX
Tel: 01327 340212
Greens Norton Medical Centre: Towcester Road, Greens Norton, Towcester, NN12 8BL
Tel: 01327 358287
Website: www.gnwmp.co.uk

NEW PATIENT REGISTRATION FORM (16 YEARS OLD AND OVER)

Please tick the appropriate tick boxes.

PERSONAL DETAILS	
Full Name:	
Date of Birth:	
NHS Number:	
Telephone Number:	
Mobile Number:	 Please tick this box if you **DO NOT** want to receive SMS correspondence from the practice ☐
Alternative Number (if applicable):	
Email Address: Please provide an email address if you are happy for us to use this as a means of contact. It is your responsibility to ensure access to your emails is secure.	

SYSTMONLINE	
Would you like to sign up to SystmOnline? This will allow you to book appointments and order medication online. If yes, you will be required to present photo ID to reception in person.	Yes ☐ No ☐

MEDICATION	
Are you currently on any repeat medications? If yes, please contact reception to make an appointment to speak to a GP.	Yes ☐ No ☐
Do you live more than one mile from a pharmacy? If yes, you can collect your medication from the dispensary at the practice. If no, you will need to collect your medication from a local pharmacy. Please nominate a pharmacy for your prescriptions to be sent to:	Yes ☐ No ☐ …………………………………..

Full Name:
Date of Birth:

MEDICAL HISTORY	
Do you have any allergies? If yes, please provide details:	Yes ☐ No ☐ ....
Smoking Status	I have never smoked tobacco ☐ I smoke ☐ Would you like help to give up smoking? Yes ☐ No ☐ I am an ex-smoker ☐

SOCIAL WORKER	
Have you ever had, or currently have, a Social Worker involved in your family? If yes, please provide brief details:	Yes ☐ No ☐ ....

CARER	
Do you look after someone? Does someone look after you? If yes, please ask reception for a Carers Information Pack.	Yes ☐ No ☐ Yes ☐ No ☐

MILITARY VETERAN	
Are you a military veteran?	Yes ☐ No ☐

NEXT OF KIN	
If you have a Next of Kin, whose details you would like to add to your medical record, please complete the following:	
Full Name:	
Relationship:	
Contact Number:	

THIRD-PARTY CONSENT	
Do you wish for somebody to have consent to access your medical record and liaise with the practice on your behalf? If yes, please ask reception for a third-party consent form.	Yes ☐ No ☐

ETHNIC CATEGORY	
Please indicate your ethnic group: This is designed to help with your healthcare, as some health problems are more common in specific communities.	....

Full Name:
Date of Birth:

SUMMARY CARE RECORD	
A Summary Care Record (SCR) is an electronic patient record. Your SCR contains name, address, date of birth, NHS number, information about medicines, any bad reaction to medicines and allergies. Allowing access to this information improves decision making in all settings where you receive healthcare. You can choose to have a SCR or choose to opt out.	
Do you have an existing Summary Care Record? **Do you wish to Opt-Out?** If yes, please complete the Opt-Out Form.	Yes ☐ No ☐ Yes ☐ No ☐
Do you have any information or communication support needs relating to a disability, impairment, or sensory loss? If yes, how can we best meet those needs?	Yes ☐ No ☐ …………………………………………………………………
Do we have your consent to include those support needs in your Summary Care Record?	Yes ☐ No ☐

SIGNATURE:		**DATE:**	

FOR STAFF USE ONLY:

☐ New Patient Health Check appointment made
☐ Repeat Medication appointment made
☐ Summary Care Record consent updated
☐ Allergies added
☐ Smoking status added
Notes Requested Yes ☐ No ☐
☐ GMS1 initialed

Completed by: ……………………….. Date: ………………………..