FOREST HOUSE MEDICAL CENTRE & WARREN LANE SURGERY
2a Park Drive
L.F.E.
Leicester LE3 3FN
Tel: 0116 2898111, web: www.foresthousemedicalcentre.co.uk

Thank you for applying to join Forest House Medical Centre & Warren Lane Surgery. We would like to gather some information about you and ask that you fill in the following questionnaire. **Please supply two forms of Identification with your completed form, a photographic form of ID (such as passport or driving licence) and proof of your home address (such as a recent bank statement or document relating to your new home)**
Please note if you do not complete the form fully you may not be able to register

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Please complete all areas in **CAPITAL LETTERS** and tick the appropriate boxes.
Fields marked with an asterix (*) are mandatory.

*Title *Surname	*First names
*Any previous surname(s)	*Date of Birth
*☐Male ☐Female	*NHS No. ☐☐☐☐☐☐☐☐☐☐
Town and country of birth	*Home address
*Home telephone No.	
Work telephone No.	*Postcode
*Mobile No. (if you have one) Do you consent to receive text messages on this number for the patient Yes ☐ No ☐	Email address

Previous address

*Previous address in the UK Postcode

Previous GP details

Name of previous doctor while at that address
Address of previous doctor

If you are from abroad

*Your first UK address where you registered with a GP if you were previously living abroad Postcode

*If previously a resident in the UK, date of leaving
*Date you first came to live in the UK if applicable

Additional details about you

What is your ethnic group?

White	☐	British	☐	Irish		
Black	☐	Caribbean	☐	African		
Asian	☐	Indian	☐	Pakistani	☐	Chinese
Mixed	☐	White + Black Caribbean	☐	White + African	☐	White + Asian
Other	☐	*Please specify*:				

Data Sharing

Summary Care Record (SCR)
The SCR is a summary of your medical history that can be shared between healthcare staff treating patients in an emergency or out-of-hours with faster access to key clinical information. **More information can be found by visiting www.nhscarerecords.nhs.uk**
Do you consent to the Summary Care Record (SCR) ?
Yes ☐ No ☐
Do you consent to the Enhanced Summary Care Record (this will include as above plus a more detailed summary of your medical history including e.g. immunisations, major diagnoses & long term conditions. Yes ☐ **No** ☐

Medical Interoperability Gateway (MIG)
Whilst the SCR mentioned shares a very small portion of your medical record across the whole NHS, the MIG shares a much fuller view of your records but only with local NHS providers – and only when you give explicit consent at the point of care.
Tick this box if you wish to opt-out of the MIG ☐

Medical details

Please attach any repeat medication you have on a regular basis.

*Are you allergic to any medicines? ☐ Yes ☐ No (if yes please specify)

*List other allergies (pollen, animal hair or certain foods. Please mark "none" if you have no other allergies that you know of)

Do you wish to nominate a pharmacy for prescriptions to be electronically sent
If yes please enter the pharmacy you wish to nominate ……
(please ask at reception for further information)

Have you ever had any of the following conditions

Polio	☐ Yes	Dates	**Whooping Cough**	☐ Yes	Dates
Diptheria	☐ Yes	Dates	**Hib**	☐ Yes	Dates
Tetanus	☐ Yes	Dates	**Hep A or B**	☐ Yes	Dates
MMR	☐ Yes	Dates	**Meningitis**	☐ Yes	Dates
Pnuemococcal	☐ Yes	Dates	**Typhoid**	☐ Yes	Dates
Yellow Fever	☐ Yes	Dates	**Other please name**	☐ Yes	Dates

List any serious illnesses asthma /diabetes/ operations / accidents / disabilities etc

***Signed**

***Date / / /**

Signed on behalf of patient (*if applicable*)
(e.g. for minors under 16 years old, adults lacking capacity)

Print name

Do you have any additional communication requirements? i.e. Braille, Large Print ……

NHS LEICESTERSHIRE COUNTY & RUTLAND

COMMUNIITY HEALTH SERVICES – CHILDREN'S
HEALTH VISITING & SCHOOL NURSING LIAISON

New registration for Children 0 – 16 years with the practice

Dear Parent / Carer / Guardian Date:

Please complete the following details about your family and leave this information at reception. This information will be shared with the Health Visitor (for pre-school children) or School Nursing Service (if school age).

Parent / s name: ……..

New Address: …….

……..

……..

……..

Previous Address: …….

……..

……..

……..

Tel. No: Home: …… Mobile: ……..

Previous GP/Base: ……

Previous Health Visitor/Base: …….

Child 1: …… D.O.B.: ……. School attends: ……NHS no……

Child 2: …… D.O.B.: ……. School attends: ……NHS no……

Child 3: …… D.O.B.: ……. School attends: ……NHS no ……..

Registering with :- ……Forest House Medical Centre……

Surgery Address: ……2a Park Drive, Leicester Forest East, Leicestershire, LE3 3FN……

If school age – Name of School: ……

Tear off slip below for Parents
✂……..……..……✂……..……..……✂……..……..……✂……..……..……✂

Health Visitor Contact is: Tel. no: 0116 2953397……..

To discuss school age health needs please contact

School Nursing Service based at: …Leysland School Clinic, Countesthorpe.……

Tel. No.: 0116 2772123……