

**PATIENT INFORMATION**

<b>Name</b>		<b>Date of Birth</b>	
<b>Telephone No</b>		<b>Mobile No</b>	
<b>Email</b>		<b>Ethnicity</b>	
<b>First Language</b>		<b>Interpreter required</b>	
<b>Address</b>			
<b>Postcode</b>			
<b>We text patients with appointment reminders and information about our services. Are you happy for us to contact you in this way?</b>			<b>YES:</b>
			<b>NO :</b>

**EMERGENCY CONTACT DETAILS**

<b>Name</b>		<b>Contact No</b>	
<b>Relationship to Registered patient</b>			

**BASIC HEALTH** (please complete smoking status and alcohol consumption for children over 14)

<b>Height</b>		<b>Weight</b>	
<b>Do you have any known allergies?</b>			
<b>Smoking Status: Please tick one of the following</b>	<b>Smoker:</b>	<b>Ex –Smoker:</b>	<b>Never Smoked:</b>

**Alcohol Consumption: How many units of alcohol you to drink per week? (please state below)**

<b>None:</b>	<b>Units:</b>	<b>per week</b>
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*\*One unit = half pint of regular beer, lager or cider, 1 small glass of wine, or 1 single measure of spirits.*

If you want to stop smoking contact One You Leeds on 0800 1694219 or via [www.oneyouleeds.co.uk](http://www.oneyouleeds.co.uk). If you are concerned about your drinking contact Forward Leeds on 0113 8872477 or via

**COMMUNICATION NEEDS**

<b>Do you have any communication, mobility or other needs?</b>	<b>Yes:</b>	<b>No:</b>
<b>If yes please specify:</b>		

**CARER DETAILS**—If you tick yes to any carer questions please speak with a member of the reception team when you hand this completed form in

<b>Are you a Carer:</b>	<b>Yes:</b>	<b>No:</b>	<b>Are you cared for:</b>	<b>Yes:</b>	<b>No:</b>
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### NOMINATED PHARMACY

**Which pharmacy would you like to nominate to collect your prescriptions from?**

<b>Pharmacy Name:</b>	<b>Address (if known):</b>

### ONLINE SERVICES

<b>Would you like to register for online services?</b> (Please tick one of the following options)	<b>Yes:</b>	<b>No:</b>
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### SUMMARY CARE RECORD

<b>Yes:</b>	I would like a Summary Care Record and express consent for medication, allergies and adverse reactions only.
<b>Yes:</b>	I would like a Summary Care Record and express consent for medication, allergies and adverse reactions and additional information (eg operations and vaccinations you have had in the past, how you would like to be treated, what support you might need).
<b>No:</b>	I do not want a Summary Care Record and express dissent (opt out) for a Summary Care Record (select this option if you DO NOT want any information shared with other healthcare professionals involved in your care).

### SHARING OF HEALTH RECORDS—OUT

**Sharing Out** – Do you want information entered here to be shareable? You will then be able to choose which other NHS care providers can view the information when you next use their services or when your

<b>Sharing Out</b>	<b>Yes (Shareable):</b>	<b>No (Not Shareable):</b>
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### SHARING OF HEALTH RECORDS—IN

**Sharing In**—Your doctor can currently view information recorded by other NHS care providers that you use. Do you want us to continue to be able to do this?

<b>Sharing In</b>	<b>Yes (Viewable):</b>	<b>No (Not Viewable):</b>
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<b>Patient Signature</b>		<b>Date</b>	
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### STAFF SECTION ONLY

<b>Staff Name:</b>		<b>Date:</b>	
<b>Documents Seen:</b>			