# ST. DAVID'S CLINIC

## NEW PATIENT REGISTRATION

**When registering your application to join our Practice we will not discriminate on grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical conditions.**

| | |
|---|---|
| **SURNAME:** | **FORENAME:** |
| **DATE OF BIRTH:** | **NHS:**<br><br>***This can be obtained from your previous surgery. If you have an NHS number this is compulsory.*** |
| **If you have recently entered the UK and not yet registered with a GP please provide the date you first came to live in the UK:** | **Date you first came to live in UK:** |
| **ADDRESS:**<br>***Please note we cannot proceed with your registration without proof of address. Bank Statement, Utility Bill or Tenancy Agreement:***<br><br>***If you do not possess this information due to no fixed abode please tick here (#13D.11)*** ☐ | **CONTACT DETAILS:**<br><br>Mobile:<br><br>Home:<br><br>Email: |
| ***Please tick box if you are happy to be contacted via text by the surgery for results, appointments etc.** ☐ | |
| **PREVIOUS ADDRESS (including postcode):** | **MARITAL STATUS:** |
| **OCCUPATION:** | |

## Ethnic Origin

Please indicate your ethnic origin. This is not compulsory but may help with your healthcare as some health problems are more common in specific communities and knowing your origins may help with the early identification of some of these conditions.

Choose one section from **A** to **F** and then tick one box to indicate your background.

**A WHITE**

| | |
|---|---|
| | British |
| | Irish |
| | Any other white background – please indicate below: |

**B MIXED**

| | |
|---|---|
| | White & Black Caribbean |
| | White & Black African |
| | White & Asian |
| | Any other mixed background – please indicate below: |

**C ASIAN OR ASIAN BRITISH**

| | |
|---|---|
| | Indian |
| | Pakistani |
| | Bangladeshi |
| | Any other Asian background – please indicate below: |

**D BLACK OR BLACK BRITISH**

| | |
|---|---|
| | Caribbean |
| | African |
| | Any other black background – please indicate below: |

**E CHINESE OR OTHER ETHNIC GROUP**

| | |
|---|---|
| | Chinese |
| | Any other – please indicate below: |

**F NOT STATED/DECLINED**

| | |
|---|---|
| | Declined: Patient chooses not to supply this information |

**Do you need an interpreter and if so what language?**

## Health and Wellbeing

| | |
|---|---|
| Do you smoke? | |
| If so how many per day? | |
| How long have you smoked? | |

St David's is committed to assisting our patients to give up smoking through Cessation Clinic and medication.

**Would you like any further advice or help? YES/NO**

| | |
|---|---|
| How much alcohol do you drink a week?<br><br>(1 pint of beer equals 2 units)<br>(1 glass of wine equals 1 unit)<br>(1 short measure equals 1 unit) | |

| | |
|---|---|
| Do you exercise? | YES/NO<br><br>If Yes, How Often? |
| Do you eat a healthy diet? | YES/NO |

| | |
|---|---|
| Height: | Weight: |
| Blood Pressure:<br>**(Please ask a receptionist)** | |

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|---|---|
| What is your medical history? | |

| | |
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| **MEDICATION**<br><br>If you are prescribed regular medication please provide your repeat slip. **Repeat slips can be obtained from your previous surgery. If this is not provided it may delay your medication.**<br><br>If this is not possible please list all medication you are currently taking including dosage and frequency, (this includes oxygen).<br><br>***PLEASE COMPLETE THE TICK BOX IF YOU ARE TAKING WARFARIN AS YOU WILL BE REQUIRED TO ATTEND THE SURGERY FOR INR MONITORING*** | **WARFARIN** ☐ |
| Do you have any allergies? | |

| | |
|---|---|
| **FAMILY HISTORY**<br><br>Please tell us about your immediate family. Any illness such as heart disease, stroke, blood pressure, asthma or diabetes | Mother: |
| | Father: |
| | Siblings: |

| | |
|---|---|
| When visiting the surgery will you use a wheelchair? | YES/NO |
| Are you blind or partially sighted: | YES/NO |
| Do you have hearing problems? | YES/NO |
| Do you have any other disability you think we should be aware of? | YES/NO |
| Are you a carer? | YES/NO |
| Are you a veteran? | YES/NO |

| | |
|---|---|
| **FEMALE PATIENTS ONLY** | Last date of smear and result: |
| | Are you using any form of contraception: YES/NO |
| | Coil : YES/NO Type: |
| | Implant: YES/NO |
| | When/Where fitted: |

| | |
|---|---|
| **REGISTRATION OF CHILDREN:**<br><br>Please provide details of the child's parents/guardian | Name:<br>Relationship:<br><br>Name:<br>Relationship: |
| Which school does child attend: | |
| Is there any social services involvement with the child? | YES / NO |
| Please provide vaccination history for this child | |

| | |
|---|---|
| **SIGNED:** | **DATE:** |

**OFFICE USE ONLY:**

**Proof of address type:**

**Staff name:**

**Date:**

***CODE FOR TEXT MESSAGE DECLINES #9NdQ.00**

# ST. DAVID'S CLINIC

## Acceptable Behaviour Contract

| **Patient's Name:** | **NHS Number:** |
|---|---|
| **Address:** | |

## Responsibility and Rights – A Patient Undertaking

| Your Rights | Your Responsibilities |
|---|---|
| St David's Practice and their staff owe to me, as a patient, a duty of care and aim to provide services to meet my needs for healthcare and treatment at all times. | I will not behave in any way, which can be considered to be violent or abusive. |
| St David's Practice and their staff aim to provide health services that are sympathetic to my individual needs within the resources which the ABUHB/Primary Care Independent Contractor has available. | **Violence** includes any incident where the St David's Practice and their staff, fellow patients and their carers are abused, threatened or assaulted in circumstances related to their work. An act of violence may involve an explicit challenge to the safety, well being or health of any member of ABUHB staff, St David's Practice and their staff or other patients. Violent behaviour may include verbal abuse, racial or sexual harassment, threats of injury, abuse of alcohol or drugs, destruction of NHS property, as well as physical acts of violence. |
| The St David's Practice and their staff are expected to treat me with courtesy and respect | **I will treat** the St David's Practice and their staff, fellow patients and their carers and visitors politely and with respect at all times. |
| The St David's Practice and their staff want to deliver appropriate and effective healthcare and treatment to me. | **I will not consume alcohol or take any form of non-prescribed medication or drugs whilst on NHS premises.** |
| The St David's Practice and their staff will only restrict or withdraw my rights to care in exceptional circumstances when I have failed to comply with any of my responsibilities in a manner which is deemed acceptable. | I accept and understand that the St David's Practice is obliged to provide a safe and secure environment for all its staff and to care for their health and safety. I accept and understand that no member of the St David's Practice team has to jeopardise their safety in providing me with care. |

I confirm that I understand that if my behaviour has been unacceptable and if I do not comply with my responsibilities as a patient, then this can result in the withdrawal of my rights as a patient and I can lose my right to receive mainstream NHS Primary Care Services.

| **Signature of Patient:** | **Date:** |
|---|---|
| **Print Name (Block Capitals):** | |

# ST DAVID'S CLINIC

## *Eligibility Form*

☐ I am a permanent resident in the UK (Wales).

☐ I am an ordinary resident in the UK (Wales) for a settled purpose (work, study) for at least six months.

☐ I have formally applied for asylum in the UK and my application is still under consideration by the Home Office.

☐ I am a refugee who has been given leave to retain in the UK.

☐ I am an EEA National (Austria, Belgium, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Irish Republic, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and Switzerland). **NEEDS VALID EHIC CARD**.

☐ I have an emergency problem which requires necessary treatment immediately (e.g. chest pain that may indicate heart attack). This would not include having forgotten medication.

☐ I am not eligible for NHS treatment and need to be seen as a private patient.*

* Charge: £45 for ten minute consultation
(Please be aware that there will be a charge payable to the chemist for a private prescription and the medication).

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I am applying for registration as a patient at this practice and I declare my eligibility as identified above.
I understand that if my declaration is later found to be false, I may forfeit my right to treatment at this practice and may be liable for the cost of treatment.

**Signed: _____ Date: _____**

(If child – signature of parent or guardian)