PAVILION SURGERY

2-3 Old Steine,
Brighton,
BN1 1EJ

https://www.pavilionsurgery.co.uk/

tel: 01273 685 588

FOR RECEPTION USE ONLY	
EMIS NUMBER:	
REGISTERED GP:	
PHOTO ID VERFIED:	
PROOF OF ADDRESS:	

Registration forms can take between 7-10 working days to process. Please ensure you have enough medication to cover this period.

Title: *(Mr, Miss, Mrs, Ms, Mx, Dr, other)*	
Full Name:	
Date of Birth:	
NHS number:	
Address & Postcode:	
Mobile number:	
Home telephone:	
Work telephone:	
Email Address:	

Supplying this information gives consent for us to contact you where medically necessary

Please confirm we have your permission to telephone, text or email you regarding your direct care (please circle):

YES **NO**

Sex assigned at birth: *We ask for your assigned sex to help us screen for sex- specific diseases such as cervical/prostate cancer*	Male/ Female /Prefer not to say
Would you describe yourself as transgender: Pronouns:	Yes / No *Eg. She/her, They/there, He/Him*
Height	
Weight	
Smoking status: If **YES**, how many per day: If **EX SMOKER**, when did you quit:	Yes / No / Ex-smoker
Profession:	
Allergies/side effects: *(Such as allergic reactions to medications, bee stings, foods, ect.)*	
Do you consider yourself to have a disability: If **YES** please give brief details	Yes/ No/ Prefer not to say
Do you have, or have you had, any serious health problems (including operations) or long term conditions? *If **YES** please include details & dates:*	Yes/No

Medications you are currently taking: *(Include dosage- you can continue on separate sheet if necessary)*	
Which pharmacy would you like your prescriptions sent to:	
Do you have any special communication requirements: *(Eg. Use of interpreter, receiving letters in large print, ect)*	
What is your main spoken language:	
Family History: **Do you have any illnesses in your family?** *Such as cancer, heart disease, diabetes, ect.* **Please include family member & health condition**	
Have you served in the armed forces: If **YES** please provide details:	Yes/No
Are you a carer: *Do family, friends or neighbours rely on you because they have long-term ill health, disability or problems with old age*	Yes/No

If **YES** would you like to be sent an information pack about help available to you?	Yes/No

Ethnicity:			
White British		White Other	
Black British		Black African	
Asian British		Black Caribbean	
Mixed white & Black African		Mixed White & Asian	
Mixed white & Black Caribbean		Other Asian background	
Other, please state:		Prefer Not to Say	

Summary Care Record	A Summary Care Record is used in Emergency Care. It contains information about your medicines, allergies & bad reactions to drugs to ensure your carers have enough information to treat you safely. Your Summary Care Record will be available to Authorised staff providing your care in England & will ask permission to look at it. Should there be an accident or illness Healthcare Staff will have immediate access to important information about your health. **A Summary Care Record will automatically be created for you unless you wish to opt out.** *If you do wish to **opt out**, please indicate here:* ☐

Alcohol Consumption:

Audit C Questionnaire						
Questions	**Scoring system**					**Your score**
	0	**1**	**2**	**3**	**4**	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	0 - 2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Scoring:
A total of 5+ indicates increasing or higher risk drinking. An overall total score of 5 or above is AUDIT-C positive.

If your score is higher than 8 and would like ***Free NHS Help*** for alcohol problems please call the Surgery on 01273 685588 or contact: www.pavilions.org.uk who offer a drop-in service at:

Richmond House,
Richmond Road,
Brighton BN2 3FT
Tel: 01273 731 900
Mon-Fri 10am-4pm & Saturday 10am-1pm.

Emergency Contact details *(someone we can contact if medically necessary)*	
Relationship status: *eg Mother, Father, Spouse, friend, flat mate..ect*	
Title: Mr, Miss, Mrs, Ms, ect	
Full Name:	
Address:	
Mobile Number:	
Home Telephone Number:	
Are they registered as a patient at Pavilion Surgery?	Yes / No

Application for online access to my medical record (OVER 16's ONLY)

A higher standard of documentation is needed for online registration. You will need two forms of documentation, one of which must contain a photo. Acceptable documents include passports, photo driving licences and bank statements, but not bills (see website for full list).

Full Name:	
Confirm Email:	
Confirm Mobile:	

I wish to have access to the following services (please tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Access my Summary Care Record (SCR)	☐

I wish to access my medical record online and understand and agree with each statement (tick):

1. I have read an understood the information leaflet provided by the practice. *(Available at the ground floor reception)*	☐
2. I will be responsible for the security of the information that I see or download.	☐
3. If I choose to share my information with anyone else, this is at my own risk.	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement.	☐
5. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible.	☐

Signature:	Date: