

Registration Pack

We are delighted to welcome you to the service!

Enclosed are a number of documents, some of which you will need to complete and return before we can process your registration.

A

NHS Wales GMS1w form

This form is required by NHS Wales to complete your registration.

 Complete and return to us!

B

Healthy Prestatyn/Rhuddlan Iach new patient questionnaire

This provides us with some baseline information which we require whilst we await the medical records to arrive from your previous GP surgery

 Complete and return to us!

C

Service Booklet

Our latest booklet is enclosed, giving you details on the services we provide, and how we work.

We will allocate your KeyTeam when we process your registration forms with you.

New patient questionnaire

Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Other: _____
Surname	
Forename(s)	
Date of Birth	
Marital Status	
Occupation	

Contact Details

Address	
Home Phone	
Mobile Phone	
Email	
Preferences	<p>From time to time we may wish to contact you by email or SMS text, for example to</p> <ul style="list-style-type: none"> ■ provide information of new services, ■ newsletters, ■ provide appointment reminders, or ■ request feedback. <p>If this is acceptable to you, please tick the boxes below</p> <p><input type="checkbox"/> Yes, you can contact me by text</p> <p><input type="checkbox"/> Yes, you can contact me by email</p>

Communication

What is your main written language?	
What is your main spoken language?	
If English is not your main spoken language do you require assistance to have a consultation in English?	

Your Medical History

Have you ever been diagnosed with any of these conditions	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	COPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you answered 'Yes' to any of conditions in the previous question please provide details here			

Medication

If you use any repeat medication then please attach a copy of your most recent request slip.

Allergies

Please provide details of any allergies you have

- I do not have allergies that I am aware of, or
- I am allergic to the following:

Lifestyle

Weight

Height

Smoking

- I have never been a smoker
- I do not currently smoke, but have done in the past
- I am a current smoker

If you are a current smoker

Would you be interested in help to quit?

- Yes
- No

How much do you currently smoke?

Alcohol	Please describe your alcohol intake on an average week:
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Exercise	Please describe the exercise or physical activity you undertake on an average week:
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Carers

Do you care for anyone because of their health or disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Does anyone care for you because of your health or disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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