Arun Practices
New Patient Form

Please:

- read this document carefully;
- select the services you wish to opt in to, and;
- complete your personal information & sign the declaration.

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ACCESSIBLE INFORMATION STANDARD

For most of us our preferred method of contact is our home number or mobile number but, for example, if you suffer from hard of hearing or blindness that method may not be suitable for you. If you, or someone you are caring for, would prefer us to make contact in another way, please indicate your preference below. We will then record your preference by highlighting it on your medical records.

Do you have an impairment and would prefer practice communications via a specific method?
YES ☐ NO ☐

If YES, please give details of your impairment below and your preferred method of communication:

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ONLINE ACCESS

Do you currently have online access? This is access to booking appointments online, ordering repeat prescriptions and viewing coded medical records.
YES ☐ NO ☐

If no, and you would like further information, please visit the surgery's website or ask at Reception.

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ELECTRONIC PRESCRIPTION SERVICE

If you have not already done so, would you like to nominate a local pharmacy so that your prescriptions go straight to them when generated?

I would like my nominated pharmacy to be:

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TEXT MESSAGING

We are able to contact you via text message with appointment confirmations and reminders.

Would you be willing to receive this information via text message?
YES ☐ NO ☐

EMAIL COMMUNICATION

We are considering emailing specific patient groups the results of assorted tests, and for chronic disease appointments. You will be advised if this is available to you.

Would you be willing to receive this information via email?
YES ☐ NO ☐

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RECORD SHARING

Do you consent to sharing your record, or the record of your child, with other healthcare providers to whom you may be referred, either now or in the future?
YES ☐ NO ☐

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DECLARATION

I consent to the surgery contacting me for the purposes of health advice, appointment confirmation and reminders, as indicated by my preferences on this document.

I understand that some services are in addition to normal practices and therefore may not take place on all occasions.

I acknowledge that the responsibility of attending appointments, or cancelling them, still rests with me.

Emails and text messages are generated using a secure facility however I understand:

- that texts are transmitted over a public network onto a personal telephone and as such may not be secure, however the practice will not transmit any information which would enable an individual patient to be identified; and
- that there may be confidential information included in test results received via email, and I am happy for this to be sent to the email address provided.

I agree to advise the surgery if my email address and/or mobile number changes, or if they are no longer in use.

I understand that I can amend/cancel these agreements at any time by contacting the practice.

Name			
Date of Birth		**Email Address**	
Mobile Number		**Home Phone Number**	
Patient Signature		**Date of Signature**	
Parent or Guardian Signature		**Relationship to Patient**	