# New Patient Registration Form

**Please complete in BLOCK CAPITALS and tick the boxes as appropriate.**

## Patient details

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Title | Mr | Mrs | Miss | Ms | Dr | First name(s) | | Middle name | |
| Surname: | | | First name(s) | | | | | Alias name | |
| Previous Surname | | | | | | Occupation | | | |
| Home Address: | | | | | | | | | |
| | | | | | | Postcode: | | | |
| Tel No: | | Mobile No: | | | | Work No: | | | |
| Email Address: | | | | | | Can we sent you emails & text messages? | ☐Yes ☐ No | | |
| What is your religion?: | | | | NHS No | | | | | |
| Name and address of previous GP: | | | | | | | | | |
| Where were you born? | | | | Date you entered the UK | | | | | |

## Next of kin

| | | | |
|---|---|---|---|
| Name: | | Relationship: | |
| Address: | | | |
| Contact number: | | If NOK for a relative in a care home is DoLs in place? | ☐Yes ☐ No |
| Does NOK have Power of Attorney? | ☐Yes ☐ No | | |
| Name & Contact Number of POA | | | |

## Children

| | | | |
|---|---|---|---|
| ☐Yes ☐ No | Date of birth | Current Nursery / School | ☐Yes ☐ No |
| | | | |
| Are you a carer for any other children? | ☐Yes ☐ No | Do you have parental responsibility? | ☐Yes ☐ No |
| Any previous involvement with Children's Social Care? | ☐Yes ☐ No | Any history of FGM / cutting? | ☐Yes ☐ No |

## Ethnicity

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| White | | British | | Black or Black British | | Caribbean | |
| | | Irish | | | | African | |
| | | Other (Please Specify) | | | | Other (please specify) | |
| Asian or Asian British | | Indian | | Mixed | | White & Black Caribbean | |
| | | Pakistani | | | | White & black African | |
| | | Bangladeshi | | | | White & Asian | |
| | | Chinese | | | | Other (please specify) | |
| | | Other (Please Specify) | | | | | |
| Eastern European | | Polish | | What is your first language? | | | |
| | | Romanian | | Do you need an interpreter? | ☐Yes ☐ No | | |
| | | Czech Republic | | Are you a refugee / asylum seeker? | ☐Yes ☐ No | | |
| | | Other (please specify) | | Are you new into the UK? | ☐Yes ☐ No | | |

| | |
|---|---|
| **GP Practice Only -** New Patient Reg Forms Checked - Staff Initial / Date | |

**Disabilities** **Summary Care Record Consent**

| | | | | |
|---|---|---|---|---|
| Are you registered disabled?<br>If yes, please give details: | ☐Yes ☐ No | | Share record | ☐Yes ☐ No |

**Medication/Immunisations/Any long term conditions**

| | | |
|---|---|---|
| Are you up to date with all your vaccinations?<br>☐Yes ☐ No | What are the names of the vaccines you have had and when did you have them? | |
| Please list any medication and the dosages: | | |
| Are you allergic to any medicines? | ☐Yes ☐ No<br>If yes, please give details | |

**Medical information**

| | Family History | Do You Suffer with | | Family History | Do You Suffer with |
|---|---|---|---|---|---|
| Epilepsy | ☐Yes ☐ No | | Blindness / Glaucoma | ☐Yes ☐ No | |
| High blood pressure | ☐Yes ☐ No | | Diabetes | ☐Yes ☐ No | |
| Heart Attack / Stroke | ☐Yes ☐ No | | Asthma | ☐Yes ☐ No | |
| Depression /mental illness | ☐Yes ☐ No | | Cancer | ☐Yes ☐ No | |
| Eczema / Hay fever | ☐Yes ☐ No | | Other | ☐Yes ☐ No | |

| | | | |
|---|---|---|---|
| Have you had a flu vaccination? | ☐Yes ☐ No | Have you had a pneumococcal vaccination? | ☐Yes ☐ No |

| | | |
|---|---|---|
| Have you had a cervical smear? | ☐Yes ☐ No | If yes, when and result if known: |

| | | | |
|---|---|---|---|
| Do you smoke? | ☐Yes ☐ No | If Yes How many do you smoke per day? | |
| Would you like advice on giving up smoking? | | | ☐Yes ☐ No |

| | | | | |
|---|---|---|---|---|
| Do you drink Alcohol? | ☐Yes ☐ No | If yes how much alcohol do you drink in a week? | Units | |

| | | | |
|---|---|---|---|
| Height in CM / feet / inches | | Weight in lbs / kgs | |
| Would you like help with managing your weight? | ☐Yes ☐ No | | |

| | |
|---|---|
| Have you ever experienced domestic abuse? | ☐Yes ☐ No |
| Are you currently experiencing domestic abuse? | ☐Yes ☐ No |
| Do you require any support? | ☐Yes ☐ No |
| Would you be interested in joining our Patient Participation Group? | ☐Yes ☐ No |
| Would you like to sign up for Patient Access Online? | ☐Yes ☐ No |

**We would like to inform you that your named GP is _____ at this practice.**

| | |
|---|---|
| **Patient Name (Print):** | **Date:** |
| **Patient Signature:** | |