PLEASE COMPLETE ALL THE QUESTIONS ON THIS FORM. IF YOU NEED ASSISTANCE WITH THIS FORM, PLEASE ASK A MEMBER OF STAFF.

ETHNICITY

PLEASE INDICATE YOUR ETHNIC ORIGIN BY WRITING THE ALPHABETIC LETTER THAT APPEARS BESIDE YOUR ETHNIC GROUP IN THE BLACK SPACE PROVIDED

Ethnic group _____

A	White	British
B	White	Irish
C	White	Any other white background
D	Mixed	White and black Caribbean
E	Mixed	White and black African
F	Mixed	White and Asian
G	Mixed	Any other mixed background
H	Asian or Asian British	Indian
I	Asian or Asian British	Pakistani
J	Asian or Asian British	Bangladenshi
K	Asian or Asian British	Any other Asian background
L	Black or Black British	Caribbean
M	Black or Black British	African
N	Black or Black British	Any other black background
O	Other ethnic groups	Chinese
P	Other ethnic groups	Any other ethnic group
Q	Not stated	

LIFESTYLE

What is your height? _____ What is your weight? _____

Do you smoke: yes☐ no☐ if yes, how many a day _____

Describe your weekly exercise: inactive ☐ moderate ☐ vigorous ☐ gentle ☐

Type of exercise *e.g. swimming, running, gymnasium etc.*

_____

Describe your diet / eating habits *e.g. vegetarian, low fat etc.*

_____

Are you allergic to any drug or medicine?

_____

Are you a carer? Yes☐ No☐ Is someone a carer for you? Yes☐ No☐

If yes please provide details of your carer:

Carers full name: _____ Contact number: _____

Is she/he registered as a carer? Yes☐ No☐

MEDICAL HISTORY

PLEASE GIVE DETAILS OF ANY SIGNIFICANT PAST MEDICAL HISTORY, PLEASE INCLUDE ANY PREVIOUS MAJOR ILLNESSES, MEDICAL PROBLEMS AND OPERATIONS WITH CORRECT DATES

History	Outcome	Date
Example: high blood pressure	*Currently on medication*	*Since 2001*

IF YOU ARE TAKING ANY REGULAR MEDICATION, PLEASE STATE THE NAME AND DOSAGE.

Name of medication	Dosage
Example: Paracetemol 500mg	*4 time a day*

Pharmacy location EPS:

_____

VACCINATIONS WITHIN THE PAST 10 YEARS INCLUDING CHILDHOOD IMMUNISATIONS

For children under 7 please bring red book or a list of all child vaccinations given.

Vaccination	Where	Date
Example: Hepatitis A	*last GP*	*01/01/2006*

FAMILY MEDICAL HISTORY

Please state any significant family medical history e.g. heat disease, and state the family member.

Illness	Family Member	Status

FEMALE PATIENTS ONLY

Last cervical smear date: _____ Results: _____

Taken where: _____ Recall date: _____

CONSENT

Patient's records are held on the computer as well as paper. GPs are responsible for the confidentiality of these records. On occasion, we share information from the patient records with the Health Authority, the local Primary Care Group/Trust, hospital and other NHS/partner organisations in the interest of patient care.

I agree to my medical records being held under the above terms and certainly that the information I have provided is correct to the best of my current knowledge.

Signature _____ **Date** ____ / ____ / _____

RIGHTS AND RESPONSIBILITIES FOR PATIENTS AND THE PRACTICE

We believe that the practice and the patients both have rights and responsibilities to ensure a friendly, courteous and efficient service provided under a safe environment. Below are some responsibilities that patients and the practice should always follow.

Patients

- You have the right to a full explanation of your illness and any tests, investigations or consultations relating to that illness.
- If you require a referral to a specialist you will be offered choice, in accordance with NHS 'Choice and Booking' agenda.
- You should treat the doctor, nurse and other staff members and patients with courtesy and respect at all times.
- As this is a busy practice, please be patient if the doctor/nurse is running late.
- Please note that it is not our policy to provide housing and social needs letters to patients. Such letters are only provided when requested by an official body i.e. the council, Social services.
- All non-NHS services will incur charges depending on the services requested, please confirm the agreed fee with staff before proceeding with your request. Any private report etc. is provided on the basis of your medical conditions and fees are charged in respect of time spent preparing such reports, therefore fees are non-refundable.
- Please note that first seven days of any sickness a self-certificate (SC2) is sufficient. However, if requested a private certificate may be issued and appropriate fee charged.
- 48h notice is required for all repeat prescriptions. Requests for a repeat medication are not accepted over the phone. Please use a SAE or attend the surgery in person. All repeat medication should be ordered in advance and not when you have run out. Repeat medication will only be issued when due, in accordance with the dose indicated by your doctor.
- The doctors will not sign passport application forms or nationality application forms.
- Please ensure a single appointment is for one person and one problem only. If you have more than one medical problem please inform the receptionist when booking your appointment.

Practice

- Everyone attending the practice is to be treated with respect and courtesy at all times, irrespective of his/her ethnic origin, religious beliefs, personal attributes or the nature of health problem.
- We will maintain your right to privacy and confidentiality and will not discuss your illness with other staff members on an unprofessional basis.

We maintain the right to remove patients from our list who display unacceptable behaviour or violence towards staff or other patients.

Please sign below if you accept these terms and conditions.

Signature _____ **Date** ____ / ____ / _____

INITIAL REGISTRATION ENQUIRY

PLEASE USE CAPITAL LETTERS

PLEASE NOTE BY COMPLETING THIS FORM YOU WILL NOT AUTOMATICALLY BE REGISTERED.

YOUR REGISTRATION WILL ONLY BE COMPLETE WHEN YOU HAVE FILLED FULL REGISTRATION FORMS.

CONTACT AND PERSONAL DETAILS

FIRST NAME: _____ SURNAME: _____

DATE OF BIRTH: ____ / ____ / _____ GENDER: ☐Male ☐Female

ADDRESS: _____

_____

E-Mail address: _____

Occupation: _____ Marital status: _____

(Please tick the preferred contact number)

Home tel☐: _____ Mobile☐: _____ Work tel☐: _____

Next of kin: _____ Relationship: _____

Contact number: _____

Country of birth: _____ City of birth: _____

If born outside the UK

Which country have you arrived from:_____

When did you arrive in to the UK: ____ / ____ / _____

Main language spoken: _____

Shared access

The practice may share your personal information with other NHS organisations where this is appropriate for your healthcare.

In other circumstances we may approach you for specific consent to release personal information to third parties. Information will not normally be released to other family members without written patient consent.

☐Yes ☐ No