Dr N Chandra & Partners

CQC overall rating

Outstanding ☆

4th August 2016

North Road Suite

RAVENSTHORPE HEALTH CENTRE

NHS

Providing NHS services

NEW PATIENT REGISTRATION FORM AGE 16 AND OVER (YOUR DETAILS)

Title: (Mr, Mrs, Ms, Miss or other.)		**Date of birth**	
 **First Name**		**Middle names**	
Surname		**Previous surname**	
Known as name		**Occupation**	
Home phone number		**Mobile number**	
Consent to SMS text service 	Do you consent to our SMS text messaging services e.g. appointment reminders please tick √ YES ( ) NO* ( ) **you will not be able to receive appointment confirmations or reminders if you opt out and if you have online service access you will not be informed when your record is accessed.*		
Email address	@		

Ethnicity	
Main spoken Language	**English ( ) and other (Please state)……..**
Religion (please state) optional	
 **Next of kin details:(your closest relative)**	
Title, Forename Surname:	
Relationship:	
Address:	
Post code	
Telephone numbers:	
DO YOU	
 **Do YOU have a 'carer'**	**Yes** ☐ **No** ☐
Are they registered at this practice	**Yes** ☐ **No** ☐
Details of carer: Full Name	
Address , post code & telephone	Post Code: / Tel:
Special circumstances **Are you an Asylum seeker?**	**Yes** ☐ **No** ☐
Traveler?	**Yes** ☐ **No** ☐

ARE YOU  **Are you a 'carer'**	
Are they registered at this practice	**Yes** ☐ **No** ☐
Details of the person you care for(if they are registered at this practice only) Full Name	**Yes** ☐ **No** ☐
	DOB / /
Address , post code & telephone	Post Code: / Tel:

SEXUAL ORENTATION *Please tick if any of the following apply; however, you do not have to disclose this information if you don't want to in doing so your GP can ensure you get any specialist help you may require:*		
Heterosexual	YES ( )	NO ( )
Lesbian	YES ( )	NO ( )
Gay	YES ( )	NO ( )
Bisexual	YES ( )	NO ( )
Transgender	YES ( )	NO ( )

Special circumstances  **Are you Housebound ?**	**Yes** ☐ **No** ☐
Do you have someone who can bring you to appointments	**Yes** ☐ **No** ☐
Details of the person can bring you for appointments **Address , post code & telephone**	Post Code: / Tel:

 **The Practice aims to provide you with information in a format you understand to help us do this please indicate if you special needs? We will do our best to provide this to you wherever possible Please state which of these apply:**		
 **Registered blind or partially sighted**	YES ( )	NO ( )
 **Registered deaf**	YES ( )	NO ( )
 **Registered disabled (nature of disability)**	YES ( )	NO ( )
 **Learning disability**	YES ( )	NO ( )
Other (please state) ***some examples dyslexia or not able to or have difficulty reading or writing***	YES ( )	NO ( )

I declare the information I am providing is correct
PATIENT SIGNATURE …… DATE: ……