

NEW PATIENT REGISTRATION AGE 16 AND OVER

| | | | |
|---|-----------------------|-------------------------|---------------|
| TITLE | | DATE OF BIRTH | |
| FIRST NAME | | LAST NAME | |
| KNOWN AS | | PREVIOUS SURNAME | |
| HOME NUMBER | | MOBILE NUMBER | |
| CONSENT TO SMS SERVICE | | YES () | NO () |
| CONSENT TO RECORD SHARING WITH OTHER HEALTH CARE PROVIDERS | | YES () | NO () |
| EMAIL ADDRESS | | | |
| | | | |
| ETHNICITY | | | |
| MAIN LANGUAGE SPOKEN | | | |
| RELIGION (optional) | | | |
| | | | |
| NEXT OF KIN | NAME | | |
| | RELATIONSHIP | | |
| | ADDRESS | | |
| | CONTACT NUMBER | | |
| | | | |
| DO YOU HAVE/ ARE YOU A CARER | YES () | NO () | |
| ARE THEY REGISTERED AT THIS PRACTICE | YES () | NO () | |
| | NAME | | |
| | ADDRESS | | |
| | CONTACT NUMBER | | |

| | | |
|---|-----------------|----------------------|
| HAVE YOU COME FROM ABROAD | YES () | NO () |
| DATE YOU ENTERED THE UK | | |
| ARE YOU A ASYLUM SEEKER | YES () | NO () |
| | | |
| SEXUAL ORIENTATION | HETROSEXUAL () | LESBIAN () |
| | GAY () | BISEXUAL () |
| | TRANGENDER () | PREFER NOT TO SAY() |
| | | |
| ARE YOU HOUSEBOUND | YES () | NO () |
| DO YOU HAVE ANYONE THAT CAN BRING YOU TO APPOINTMENTS | YES () | NO () |
| | | |
| ARE YOU REGISTERED BLIND OR PARTIALLY SIGHTED | YES () | NO () |
| ARE YOU REGISTERED DEAF | YES () | NO () |
| ARE YOU REGISTERED DISABLED | YES () | NO () |
| DO YOU HAVE ANY LEARNING DISABILITIES | YES | NO |
| | | |
| DO YOU HAVE ANY LONG TERM HEALTH CONDITIONS | YES () | NO () |
| PLEASE INDICATE HEALTH CONDITION | | |
| ARE YOU ON ANY MEDICATION | YES () | NO () |
| PLEASE INDICATE MEDICATION | | |
| NOMINATED PHARMACY | | |

I DECLARE ALL INFORMATION I HAVE PROVIDED IS CORRECT

PATEINT SIGNATURE _____ DATE _____

OFFICE USE ONLY

| | |
|--|--|
| NAME OF PERSON ACCEPTING FORM | |
| DATE OF ACCEPTING THE FORM | |
| NAME OF PERSON INPUTTING FORM | |
| DATE OF INPUTTING FORM | |
| NP APT DATE (for long term conditions) | |