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WHITTINGTON MOOR SURGERY

NEW PATIENT REGISTRATION FORM

Please fill in as much of the Registration form as possible, anything with a * is compulsory

DEMOGRAPHICS : NHS Number _____ *Date of Birth _____

Title: Mr Mrs Miss Ms Other _____ *Sex: M / F *Age _____

*First Name: _____ *Surname _____

*Previous Surname/s _____

* Town & County of Birth _____

*Address _____

_____* Postcode _____

*Home Phone _____ *Mobile Phone _____

Email Address _____

*Can we contact you via Text Message YES/NO Can we contact you via email YES / NO

*What is your Ethnic Origin _____ *What is your First Language_____

Please help us trace your medical records by providing the following information

*Previous Address in the UK:

_____

_____ Postcode: _____

*Are You from Abroad? YES/NO

*If previously resident in the UK, date of leaving:

_____

*Date you first came to live in the UK:

_____

*Name of Previous GP:

_____

*Address of Previous GP:

_____

*If you are returning from the Armed Forces, The last base you lived at:

ARMY _____ (XaP9d) Service or Personnel Number _____

NAVY _____ (XaP9f) Enlistment Date: _____

RAF _____ (XaP9g) Discharge Date: _____

OCCUPATION – (*present or last known)*

_____

ACCESSIBLE INFORMATION STANDARDS:

*Do you have any communication or information needs relating to a disability/impairment or sensory loss? Yes / No *(for surgery use only, if no Y17f3)*

If yes, please let us know what these are so we can do our best to support you:

*(Y17f2)*_____

_____

_____

NEXT of KIN *(If you wish this information to be entered on your record)*

Name _____ Relationship to you

_____

Address _____ Contact Phone Number

_____

CARERS: Do you look after any of the following (who need support due to physical or learning disability/illness) Relative ☐ Child ☐ Friend ☐

If yes and you would like more information please ask for our Carer's leaflet – you may be entitled to free annual influenza vaccinations

SMOKING

Do you smoke? YES / NO OR Used to smoke but gave up in/on *(please give date)*

_____

If Yes: Cigar / Cigarettes How many per day _____

Have you considered giving up? YES / NO

Are you interested in advice to help you stop smoking? YES / NO

DO YOU HAVE ANY ALLERGIES WE SHOULD KNOW ABOUT? YES / NO

If YES please give details_____

SCR – Summary Care Record

"Your Emergency Care Summary"

*If you wish to have a Summary Care Record with additional information please tick the box ☐

If you would like any more information regarding this please ask the receptionist or visit www.nhscarerecords.nhs.net

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