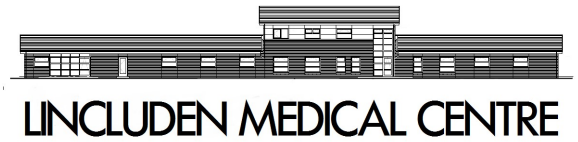
New Patient Registration Form



Title: (Mr/Mrs/Miss): _____

Surname: _____

Forename: _____

Date of Birth: _____

Contact Details:

Tel Home:_____ Tel Work: _____

Mobile_____ Email: _____

Next of Kin_____ Tel.No._____

By giving you my mobile number and email address, I consent to the practice contacting me by text message and/or email for the purposes of appointment reminders, health promotion or practice updates.
I acknowledge that appointments reminders by text are an additional service and that they may not be sent on all occasions but that the responsibility for attending appointments or cancelling them still rests with me.
Text messages are generated using a secure facility but I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure, however the practice will not transmit any information which would enable an individual patient to be identified.

Signed: _____ Date: _____

Ethnic Origin: Please tick one of the following

White British		Bangladeshi (Asian or Asian British)	
White Irish		Any other Asian background	
Any other White background		Caribbean (Black or Black British)	
Mixed White & Black Caribbean		African (Black or Black British)	
Mixed White & Black African		Any other Black background	
Mixed White and Asian		Chinese	
Any other mixed background		Any other ethnic category	
Indian (Asian or Asian British)		Prefer not to state	
Pakistani (Asian or Asian British)			

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Health Information:

Are you allergic to any medications? If so, please list:

_____

_____

Height: _____ Weight: _____

Do you smoke? YES / NEVER / Ex Smoker If yes, how many per day? _____

Do you drink alcohol? YES / NO If yes, how many units on average per day?_____

Do you follow any special diet? _____

Do you have any of the following health conditions:

COPD	YES / NO	Asthma	YES / NO
Diabetes	YES / NO	Heart Disease	YES / NO
Stroke	YES / NO	CKD	YES / NO
Angina	YES / NO	Hypertension	YES / NO
Epilepsy	YES / NO	Medication for Mental Health issues	YES / NO

Do you have any family history of the following:

Condition	**Family Member(s)**	**Age When Diagnosed**	
Asthma			
Diabetes			
Stroke			
Angina / Heart Attack			
Other Heart Disease			Type of Cancer
Cancer			

If you are unable to provide a repeat prescription slip, please list all current medication, with dosage, below: _____

_____

_____

_____

_____

PLEASE COMPLETE BOTH SIDES OF THIS FORM