

# NEW PATIENT REGISTRATION



In order for you to be registered with this practice you must be 'lawfully living in the UK, voluntarily for a settled purpose' for over 6 months and reside in the practice area. Please confirm that you fulfil these criteria by signing below:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(You will be asked to provide proof of your residency and the following documents are some of those acceptable for this purpose; a NHS medical card, a utility bill, a letter from a host family or college or a passport).

It is very important for both you and us that the details we hold for you are correct and up to date. Please spare a few minutes to complete the following questions and return this form to us. Please tick where indicated.

Thank you.

## PATIENT DETAILS

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_

Contact telephone number: \_\_\_\_\_ Work telephone number: \_\_\_\_\_

Mobile telephone number: \_\_\_\_\_ NHS No: \_\_\_\_\_

## ETHNICITY

British/Mixed  Chinese  Black/Black British  Asian/Asian British  Other Ethnic Group

## FIRST LANGUAGE

English  Other  If other please state \_\_\_\_\_

## SMOKING

I am a smoker  I am an ex-smoker  I have never smoked

## ALLERGIES

Please list any known allergies \_\_\_\_\_

HEIGHT (FT/INS OR CMS): \_\_\_\_\_

WEIGHT (ST/LBS OR KGS): \_\_\_\_\_

HOW MUCH EXERCISE PER WEEK: \_\_\_\_\_

**ALCOHOL**

(Please tick where appropriate)

**How often do you have a drink which contains alcohol?**

Never  Monthly or less  2-4 times per month  2-3 times per week  4+ times per week

**How many units do you have on a typical day when you are drinking?**

1 - 2  3 - 4  5 - 6  7 - 8  10+

**How often do you have 6 or more units on one occasion?** (1 unit = ½ pint beer or 1 small glass wine or 1 single shot spirit)

Never  Less than monthly  Monthly  Weekly  Daily or almost daily

**FAMILY**

Is there anyone **already registered or going to register** at The Birchwood Practice living at the address overleaf?

If so, what is their name:

.....

Are they next of Kin?

Yes  No

Relationship to you:

.....

Telephone number:

.....

Do you live alone?

Yes  No

**Do you have any special needs? If so please state:**

.....

**CARERS/CARED FOR**

My carer is / I care for:

.....

Address

.....

Telephone number:

.....

If any of the information changes please inform us as soon as possible so we can amend our records.  
The Birchwood Practice is registered under the Data Protection Act.

Thank you for completing this form; it will be treated as highly confidential.

We hope you will be very happy with our practice.