New Patient Registration Form

Fields marked with an asterisk (*) are compulsory.

Filling this form will NOT automatically register you with the surgery. You are required to present in person to sign your registration form and provide I.D. (such as a driving licence) and proof of address (such as a bill). Sending this form does NOT guarantee that you will be accepted onto the practice register.

Patient Details

Title (Mr. Mrs. etc.) *Date of Birth

*Surname

*Forename(s)

Previous Surname

Previous Forename(s)

*Sex Assigned at Birth ☐ Male ☐ Female ☐ Other Please Specify

*Gender ☐ Male ☐ Female ☐ Other Please Specify

*NHS Number

*Town and Country of Birth

*Address

Postcode

*Phone Mobile

E-mail

Previous Address

Postcode

Next of Kin

Next of Kin Phone

Information About You

Your Height Your Weight

Your First Language

Do you speak English? ☐ Yes ☐ No

Marital Status

Occupation

Religion

Ethnicity

White: ☐ British ☐ Irish ☐ Other

Black: ☐ British ☐ African ☐ Caribbean ☐ Other

Asian: ☐ Chinese ☐ Indian ☐ Pakistani ☐ Other

Mixed: ☐ White + Black British ☐ White + Black African ☐ White + Black Caribbean

☐ White + Chinese ☐ White + Indian ☐ White+ Pakistani

Other:

Previous GP

Name of GP

Address

Postcode

If You Are From Abroad

First UK address where Registered with a GP

Postcode

If a previous UK resident, date of leaving

Date you first came to live in the UK

Other Information

Are you a carer? ☐ Yes ☐ No Do you have a carer? ☐ Yes ☐ No

Preferred Pharmacy

Do you give consent to access all our online services (i.e. MyGP App)? ☐ Yes ☐ No

Do you give consent to share your medical records with other organisations (i.e. Hospitals, Referrals) ☐ Yes ☐ No

Medical Information

Please list any serious illnesses / operations / accidents / disabilities (and for women any pregnancy related problems) and the year they took place:

Have you ever suffered from: (Tick as appropriate)

☐ High Blood Pressure	☐ Blindness/Glaucoma	☐ Eczema
☐ Epilepsy	☐ Diabetes	☐ Hay Fever
☐ Heart Attack	☐ Heart Condition	☐ Stroke
☐ Cancer	☐ Asthma	☐ COPD
☐ Thyroid Problems	☐ Depression	☐ Mental Health Problems

Please provide proof of any medications you are on. (e.g. the tear off section of a prescription slip)

Do you have any allergies?

Drug Allergies	Other Allergies

Cervical Screening

Have you ever had a cervical smear? If yes, please state when and the result:

☐ Yes ☐ No When Result

Smoking

Never smoked ☐

Do you Smoke? ☐ Yes ☐ No

If yes, how many a day?

Are you an ex-smoker? ☐ Yes ☐ No

If yes, date stopped

Alcohol

1 drink = 1/2 pint of beer or 1 glass of wine or 1 single measure of spirits

Do you drink? ☐ Yes ☐ No If yes, how many units do you drink a week?

Vaccinations

Please tick and give dates where possible

☐ Polio
☐ BCG
☐ Yellow Fever
☐ Tetanus
☐ Typhoid
☐ Other
☐ Pneumonia
☐ Rubella
☐ Hepatitis A/B
☐ Flu
☐ Covid-19

Family History

Have any of your blood relatives suffered from the following? If so, please state who.

☐ Asthma ☐ Eczema ☐ Hay Fever - Relationship
☐ Blindness/Glaucoma
☐ Blood Pressure
☐ Epilepsy
☐ Strokes
☐ Diabetes
☐ Tuberculosis
☐ Cancer
☐ COPD
☐ Thyroid
☐ Heart Disease

Would you like to share any other health information about yourself that has not already been covered in this form?

Signature

Signature

Date