NEW PATIENT REGISTRATION	
First Name(s):	Last Name:
Title: Mr / Mrs / Miss / Ms / Other …..	
Date of Birth	
Home Telephone Number	
Work Telephone Number	
Mobile Telephone Number	
Email address (by giving an email address you agree to be sent healthcare / administrative information)	
Next of Kin	
Emergency Contact YES/NO Relationship to Patient: Title: Full Name: Address:	Contact Number(s): Can collect results? YES / NO Can discuss Records? YES / NO

Your Ethnic Origin (select one)

White British 9i0	White Irish 9i1	White Other 9i2	
Mixed White & Black Caribbean 9i3	Mixed White and Black African 9i4	White & Asian 9i5	Other Mixed Background 9i6
Indian / British Indian 9i7	Pakistani / British Pakistani 9i8	Bangladeshi / British Bangladeshi 9i9	Other Asian Background 9iA
Caribbean 9iB	African 9iC	Other Black Background 9iD	Chinese 9iE
Other 9iF	Declined / Not given 9iG		

Your main or 1st Language Spoken / Understood (select one)

English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi	Polish
Ukrainian	French	German	Spanish	Other: (Please Specify)		

Specific Needs: Please detail below any specific needs you have so the practice can ensure they are identified and accommodated by taking the appropriate action	
Do you require the help of a Translator / Interpreter?	
Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):	
Are you an 'Assistance Dog' User?	
Please state any Physical disabilities you have	
Do you have any communication / information needs relating to a disability, impairment or sensory loss, and if so, what are they?	
Are you a carer? YES/NO If Yes, how long have you been a carer?	
Do you have a carer? YES/NO If Yes, could you please supply the following information:	
Details of Carer Title: First Name: Last Name: Address:	Contact Number(s): Is your carer related to you? YES /NO If yes, what is the relationship?
Sign here if you wish us to disclose information about your health to your carer. Signed: Date:	

Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	**Yes / No**	If "Yes",please bring a written copy for your records
Have you nominated a Power of Attorney	**Yes / No**	If "Yes", please bring a written copy for your records
Do you want a named relative/friend to be able to collect results for you?	**Yes / No**	If different from Next of Kin, please give details:

HEALTH STATUS QUESTIONNAIRE

Height:	Weight:
Exercise: What type?	How often?
Do you smoke? YES/NO	If Yes, what type? How many per day?
Would you like support and/or information on giving up? YES/NO	
Are you an ex-smoker? YES/NO	If Yes, Please state year stopped: How many did you smoke?
Never smoked? YES/NO	

Alcohol Consumption

Questions	Tick the relevant boxes				
How often do you have a drink containing alcohol?	Never	Monthly or less	2 – 4 times per month	2 – 3 times per week	4+ times per week
How many standard drinks of alcohol do you drink on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 9	10+
How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

Your Medical Background

What illnesses have you had and when?	
What operations have you had and when?	
Do you have any medical problems at present?	
Allergies: Please list any drug and food allergies you have	

Current Medications

Please list the name, dose and how often you are taking the medication. If possible please provide us with a repeat prescription slip from your previous GP surgery.

Name	Dose	How many times during the day do you take it?

Family Medical History

Have you or any of your immediate relatives (brothers/sisters/parents) had any of the following. Tick box if applicable and give details if you can.

	TICK	Details	Relationship	Date (if known)
Heart attack or angina before age 60				
Heart attack or angina over age 60				
Asthma				
Diabetes				
Stroke				
Cancer				
Any inherited diseases				

Patient Signature ……..… Date ……

Or Signed on behalf of the patient …… Date ……

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or see our website: www.newbridgesurgerywolverhampton.nhs.uk