# NEW PATIENT REGISTRATION FORM

**PERSONAL DETAILS – please provide proof of identity (photographic ID: driving licence or passport) and proof of address (utility bill or bank statement) for your registration to be completed.**

| | |
|---|---|
| ☐Mr ☐Mrs ☐Miss ☐Ms | **Surname:** |
| **Date of birth: / /** | **First Names:** |
| **NHS Number:** | **Preferred Name (if not First Name):** |
| **Town and Country of Birth:** | **Previous Surname(s):** |

**Home Address:**

| | |
|---|---|
| **Postcode:** | **Home Telephone:** |
| **First Language:** | **Mobile Telephone:** |
| **Occupation:** | **Work Telephone:** |

**Ethnicity:**

**White**: ☐ British ☐ Irish ☐ Any other White background ……………………………………………………………………………………

**Mixed:** ☐ White and Black Caribbean ☐ White and Asian ☐ Any other mixed background ……………………………………….

**Asian or Asian British:** ☐Indian ☐ Pakistani ☐ Bangladeshi ☐ Any other Asian background……………………………………

**Black or Black British:** ☐ Caribbean ☐ African ☐ Any other Black background…………………………………………………………

**Chinese or Other Ethnic Group:** ☐Chinese ☐ Any Other Ethnic Group ……………………………………………………………………

**I do not wish to disclose my ethnic origin** ☐

**PLEASE HELP US TO TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING INFORMATION**

| | |
|---|---|
| **Your previous address in the UK:** | **Name of previous doctor while at that address:**<br><br>**Address of previous doctor:** |

**IF YOU ARE FROM ABROAD**

**Your first address where registered with a GP:**

| | |
|---|---|
| **If previously resident in UK, date of leaving:** | **Date you first came to live in UK** |

**IF YOU ARE RETURNING FROM THE ARMED FORCES**

**Address before enlisting:**

| | |
|---|---|
| **Service or Personnel Number:** | **Enlistment date** |

**REGISTERING CHILDREN 0 – 16 YEARS**

If you are registering children please ensure that you have also completed a **Notification of Child/Children to Health Visitor** form which is available from reception.

**SOCIAL DETAILS**

**NEXT OF KIN**

**Full Name:**

| | |
|---|---|
| **Relationship:** | **Contact Details:** |

**CARERS** **Carers Packs are available from reception.**

Do you care for another person who because of disability or the effects of age cannot manage at home without help?

☐ Yes ☐ No If Yes, would you like to be signposted to Herefordshire Carers Support (HCS) ☐ Yes ☐ No

***HCS is a charity organisation providing support, information and advice to the Carers of Herefordshire.***

If you are happy for us to include information about the person you care for in your medical record then please complete the questions below.

**Name of Person that you care for:**

**Relationship to Person that you care for:**

## SMOKING STATUS

| | |
|---|---|
| ☐ Never Smoked | |
| ☐ Ex-smoker | Date stopped: / / Amount per day…………………….. |
| ☐ Smoker | Amount per day…………………….. |

If you would like help to give up smoking please ring 0800 169 0169 or visit www.nhs.uk/smokefree.

## ALCOHOL CONSUMPTION

For the questions below please circle the answer which best applies to you.
**1 unit = 1/2 pint of beer** or **1 glass of wine** or **1 single spirits**

| | 0 | 1 | 2 | 3 | 4 | SCORE |
|---|---|---|---|---|---|---|
| How often do you have 8 units (men) or 6 units (women) or more on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| **If your score to the question above is 2 or more please continue to answer the questions below.** | | | | | | |
| How often during the last year have you been unable to remember what happened the night before because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often during the last year have you failed to do what was normally expected of you because of your drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| In the last year has a relative or friend, or a doctor or health worker, been concerned about your drinking or suggested you cut down? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| **Scoring: A total of 3+ indicates hazardous or harmful drinking** | | | | | **TOTAL SCORE** | |

## OTHER INFORMATION YOU MAY WISH US TO RECORD

Please detail here any specific needs that you may have (for example allergies, disabilities, religious or cultural needs).

## ELECTRONIC PRESCRIBING SYSTEM

We can send your repeat prescriptions electronically to a pharmacy of your choice. If you would like to nominate a pharmacy please note the name and location below so that we can update your medical records:

**Pharmacy Name:** **Pharmacy Location (Town):**

## DATA SHARING IN GENERAL PRACTICE

Data is shared across the NHS to improve services and care provided to patients. It is also very important to us to protect your personal ad confidential information. Most of the information that we are obligated to share is anonymised and not identifiable to you as an individual. If identifiable information is going to be shared with an outside agency we will always ask your permission to do so before it is released. If you do not wish for any data to be released you can opt out or block your records from being shared. Before doing this please read the 'Data Sharing in Herefordshire' leaflet which is available from reception or via our website.

## ORGAN DONATION

If you would like to join the organ donor register please visit www.uktransplant.org.uk or call 0300 123 23 23.

## ONLINE SERVICES (Patient Access)

You can book and cancel your appointments, order repeat prescriptions, view parts of your medical record and update contact details online. Please visit reception with photographic ID for more information and to register for these services.

## SIGNATURES REQUIRED

**Patient**

| | | |
|---|---|---|
| X………………………………………………………… | Date: / / | ☐ Signature of patient<br>☐ Signature on behalf of patient |

**Doctor**

| | | |
|---|---|---|
| X………………………………………………………… | Date: / / | **HA Code:** |