New Patient Registration Form

TORRINGTON HEALTH CENTRE

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

Please bring a Passport/Driving Licence to confirm your date of birth and address.

Please complete a separate form for each family member to be registered.

<table>
<tr><td colspan="5">Full Name:</td><td colspan="2">Telephone Number:</td></tr>
<tr><td colspan="5">Mr / Mrs / Miss / Ms / Other……..</td><td colspan="2">Work Number</td></tr>
<tr><td colspan="5" rowspan="4">Address and Postcode</td><td colspan="2">Mobile Number:</td></tr>
<tr><td colspan="2">E-mail Address:</td></tr>
<tr><td colspan="2">Next of Kin:</td></tr>
<tr><td colspan="2">Next of Kin Contact Number:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td colspan="3">Previous / Mother’s surname if different:</td><td colspan="2">Town & Country of Birth</td></tr>
<tr><td>Marital Status:</td><td></td><td>Gender:</td><td>Male:</td><td>Female:</td><td colspan="2" rowspan="2"></td></tr>
<tr><td colspan="5">Occupation:</td></tr>
<tr><td colspan="5" rowspan="3">Names & Ages of Children

Previous Address</td><td colspan="2">Previous Postcode:</td></tr>
<tr><td colspan="2">Previous Doctor Telephone No.</td></tr>
<tr><td>Your height:</td><td>Feet / inches</td><td>cm</td><td>Your weight:</td><td>Stones / lbs.</td><td>kg</td></tr>
<tr><td colspan="7"></td></tr>
</table>

Your Religion:	C of E	Catholic	Other Christian (state)	Buddhist	Hindu	Muslim
	Sikh	Jewish	Jehovah's Witness	No religion	Other religion (state)	

Your Ethnic Origin: (select one)	White (UK)	White (Irish)	White (Other)
Caribbean	African 9i4	Asian 9i5	Other Mixed Background
Indian / Brit Indian	Pakistani / Brit Pakistani	Bangladeshi / Brit Bangladeshi 9i9	Other Asian Background
Other Black Background	Chinese 9iE	Other 9iF%	Ethnic Category not stated

Your main or 1st language Spoken / Understood: (select one)	English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi
Polish / Ukrainian	French	German	Spanish	Other: (Please Specify)		

Smoking and Exercise:					
Are you currently a smoker?	Yes	No	Have you ever been a smoker?	Yes	No
If you are a smoker and want to stop, please ask for information about local smoking cessation services.					

How often do you exercise?	No. times per week	Type(s) of exercise:	

Your Medical Background:	
What health problems do you have or have had in the past and when?	
What operations have you had and when?	
Do you have any medical problems at present?	
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)	

Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)	**Diabetes**	**Heart Attack**	**Heart attack under age of 60**	**Bowel Cancer**		
	Breast Cancer		**High Blood Pressure**	**Asthma**	**Stroke**	
	Thyroid Disorder		**Any other important Family Illness?**			

What immunisations have you had? (please tick all that apply)	**Diphtheria**	**Measles**	**German Measles**	**Tetanus**	**Polio**	**MMR**
	Whooping Cough		**Pre-school booster**	**Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses**		

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:**	
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:	
Please state any Mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises	
Please state any Religious or Cultural needs:	
Do you require the help of a Translator / Interpreter?	
Please state any specific nutritional requirements you have:	
Please state any allergies and sensitivities you have:	
Please state any phobias you have:	
If you are a Carer, please state the name / address / phone number of the person you care for:	**Person Cared For Contact Details:**
If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer Contact Details:**

	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", can you please bring a written copy of it to your New Patient Consultation***
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	**Yes / No**	**If "Yes", please state their name / address / phone number:**

Summary Care Record

The NHS Summary Care record is an electronic record of important information about your health. It will be available to health care staff providing your NHS Care.

Are you happy to have a Summary Care Record?	**Yes**	**No**

When we refer you to another health professional for care we need to give then your medical history so they are aware of your health & any medication you are taking.
If for any reason you do not want us to share your medical history please inform the doctor at the time of referral

Patient Signature:		**Signature on behalf of Patient:**	
		Name of person signing on behalf of patient	

For more information about the services we offer, please refer to our website:
******www.torringtonhc.co.uk******