**MANSFIELD MEDICAL CENTRE CHILD**

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| --- |
| **Date** |

# New Patient Registration Form

Please complete this confidential questionnaire in full; if it is NOT completed correctly it will delay your registration. Please allow up to 14 days for the registration to be complete

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

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

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

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| **First Name:** | **Surname:** | **Telephone Number:** |
| **Mr / Mrs / Miss / Ms / Other……..** | **Work Number** |
| **Address and Postcode** | **Mobile Number:** |
| **E-mail Address:** |
| **Next of Kin:** |
| **Next of Kin Contact Number:** |
| **Date of Birth:** | **Previous / Mother’s surname if different:** | **Town & Country of Birth** |
| **Marital Status:** |  | **Gender:** | **Male:** | **Female:** | **Other residents of your home:** |
| **Occupation:** |
| **Names & Ages of Children** |
| **Housing****(Select one)** | **House** | **Maisonette** | **Flat** | **Mobile Home** | **NHS Number (If Known)** |
| **Previous Address** | **Previous Postcode:** |
| **Previous Doctor Telephone No.** |
| **Previous Doctor Name & Address:** | **Previous data released?** | **Yes** | **No** |
| **If applicable, date you** **first came to live in Britain:** |
| **If returning from** **Armed Forces:** | **Your Service or Personnel Number** | **Your Enlistment Date** |
| **Your****height:** | **Feet / inches** | **cm** | **Your****weight:** | **Stones / lbs.** | **kg** |
|  |
| **Your****Religion:** | **C of E** | **Catholic** | **Other Christian (state)** | **Buddhist** | **Hindu** | **Muslim** |
| **Sikh** | **Jewish** | **Jehovah’s Witness** | **No religion** | **Other religion (state)** |
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| **Your Ethnic Origin:****(select one)** | **White British/Mixed British** | **Irish** | **White European** |
| **Caribbean** | **White & Black Caribbean** | **African** | **Polish** |
| **Indian /****British Indian** | **Pakistani /****British Pakistani** | **Other Asian****Background** | **Turkish** |
| **Other Black****Background** | **Chinese** | **Lithuanian/Lativan** | **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, Alcohol Consumption and Exercise:** |
| **Are you currently a smoker?** | **Yes** | **No** | **Have you ever been a smoker?** | **Yes** | **No** |
| **If so, how many cigarettes / cigars / tobacco do you smoke in a week?** |  | **How much alcohol do you drink in a week (Units)?***(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)* |  |
| *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 illnesses have you had & 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 you able to administer your own medicines?** | **Yes** | **No – please detail specific issues (e.g. swallowing, opening containers)** |
| **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?** |
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| **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 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:** |  |
| **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:** |
|  |
| **Summary Care Records.** |
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|  | **Mansfield Medical Centre is supporting Summary Care Records and as a patient you have a choice if you DO NOT want a summary care record then please tick the box and ask at reception for a opt out form. You should do this even if you have already completed a form at your previous practice. You are free to change your decision at any time by informing the practice.** | **No** |  |
|  |
| **Patient Participation Group****The Practice is committed to improving the services we provide to our patients.** **To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.** **By expressing your interest, you will be helping us to plan ways of involving patients that suit you.** **It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.****If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.**  |
| **Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the “Yes” Box)** | **Yes** |
|  |
| **Patient****Signature:** |  | **Signature on****behalf of Patient:** |  |

***Your physical examination will include having your height, weight and blood pressure taken, and a specimen of urine for testing (it would be helpful if you would bring a specimen with you when coming to the Practice).***

***The Consultation will also establish relevant past medical and family history, including:***

* ***Medical factors - illnesses, immunisations, allergies, hereditary factors, screening tests, current health***
* ***Social factors - employment, housing, family circumstances***
* ***Lifestyle factors - diet and exercise, smoking, alcohol and drug abuse.***

**Thank you for completing this form**

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