NEW PATIENT REGISTRATION FORM

Please complete the sections below in addition to the family doctor services registration form and return to us with a copy of photo ID, proof of address and a list of your medication. This must be a repeat slip or printout from your previous practice.

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| Title: |  |
| Surname: |  |
| First name(s): |  |
| Date of birth: |  |
| Address & Postcode:  Please advise us should you move house in the future. |  |
| Contact details: | Home phone number:    Mobile:  Please tick to receive text updates  and reminders:  Email address: |
| Next of Kin:  So that your records remain current, please remember to update us if these details change at any point. | Name:  Telephone Number:  Relationship to patient: |
| Carer information: | Do you have a carer?  YES NO  Are you a carer?  YES NO  If you have answered yes to either of the above, we will supply you with a carer registration form. |
| Living Will and Power of Attorney | Please provide copies of relevant documentation if you have either of these in place. |
| Have you previously been registered with Estuary Group Practice? | YES NO |
| Ethnicity: |  |
| Main language: | Do you require an interpreter?  YES NO |
| Occupation: |  |
| Military Veteran Status: | Are you a military Veteran?  YES NO |
| Previous occupation if retired/unemployed: |  |
| Details of members of your household who will be registering with the practice:  This will enable us to link families together on our system. | Name and date of birth:  Name and date of birth:  Name and date of birth:  Name and date of birth: |

Health history

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| Have you been diagnosed with any of the following? | Stroke/TIA Diabetes  Heart failure Dementia  Asthma COPD  Coronary heart disease  (angina/heart attack)  Hypertension |
| Have you had any operations in the past or any other significant health issues not listed above? | YES NO  If YES please give details: |
| Do you have a disability or any sensory/ communication difficulties? | YES NO  If YES please give details: |
| Smoking history: | Never smoked Ex-smoker  Smoker how many/day \_\_\_\_\_\_\_\_\_ |
| Alcohol consumption: | Teetotal Ex-drinker  Drinker units/week \_\_\_\_\_\_\_\_\_\_ |
| Blood pressure: | If known, please state your recent blood pressure below. This can be obtained from a local pharmacist and is helpful for monitoring purposes.  \_\_\_\_\_\_/\_\_\_\_\_ on \_\_\_\_\_\_\_\_  Are you currently prescribed anti-hypertensive medication?  YES NO |
| Weight: | What is your current weight?  \_\_\_\_\_\_\_\_ kg/st on \_\_\_\_\_\_\_\_\_ |
| Height: | How tall are you?  \_\_\_\_\_\_\_\_\_\_\_\_ ft/m |

Medication, allergies and family history

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| Are you taking any regular medication?  **Please attach your reorder form if you have this available – this will ensure there are no delays in processing your initial prescription request** | YES NO  If YES please give details including medication name, dose and frequency |
| Do you have any known drug allergies? | YES NO  If YES please give details: |
| Family history | Is there any significant family history that we should be aware of:  YES NO  If YES please give details, including which relative this relates to. |