TRINITY MEDICAL CENTRE

New patient registration form

Please complete this questionnaire and return it to the surgery with your GMS1 registration document, photo ID and a recent proof of address.

Date form completed: ………………………..

Surname: ……………………………………………………………………………………..

First Names: ……………………………………………………………………………………….

Date of Birth: …………………………….. Date form completed: …………………..

Sex: *Please tick*: [ ] Male [ ] Female [ ] Transgender [ ] Other [ ] Prefer not to say

Contact Details:

Home: …………………………………………………… Work: ………………………………………

Mobile: ……………………………………………………

Email: ……………………………………………………………………………………………………

Nominated Pharmacy (prescriptions to be sent to): ……………………………………..

Ethnic Origin: *Please tick*

( ) African
( ) Bangladesh/British Bangladesh
( ) British/Mixed British
( ) Caribbean
( ) Chinese
( ) Ethnic Category not stated
( ) Indian/British Indian
( ) Irish
( ) Other Asian Background
( ) Other Black Background
( ) Other Mixed Background
( ) Other White Background
( ) Pakistani/British Pakistani
( ) White and Asian
( ) White and Black African
( ) White and Black Caribbean

Do you need an interpreter? *Please tick*: [ ] Yes ………………………………… [ ] No

Do you have any communication/information needs relating to a disability, impairment or sensory loss? *Please tick:* [ ] Yes [ ] No

If "Yes", what are those needs? ……………………………………………………………………….

Do you have a main carer or are you the main carer for a vulnerable person?
Please tick. [ ] Yes [ ] No

If yes please provide details: ……………………………………………………………………….

Are you housebound? Please tick: [ ] Yes [ ] No

Next of Kin details: **Name**: ………………………………………………………………………………

Contact: …………………………………………… **Relationship**…………………………………………

Do you suffer from any drug allergies? *Please tick*: [ ] Yes [ ] No

If "yes" please give details: ……………………………………………………………………………..

Do you suffer from any other allergies? *Please tick*: [ ] Yes [ ] No

If "yes" please give details: ……………………………………………………………………………..

Contraception: *Please tick*:
Not needed [ ] Oral contraception [ ] IUCD [ ] (date inserted……./……./……./)

Depo [ ] Condoms [ ]

***ABOUT YOUR FAMILY*:** Does any member of your family have any of the following?

Condition	Relationship	Age at Diagnosis
Heart Problems		
Stroke / CVA		
High Blood Pressure		
Asthma		
High Cholesterol		
Epilepsy		
Cancer		
Glaucoma		
Diabetes		

Please record your current **Height**: …………………….**cm** **Weight**: ……………………. **Kg**

You are welcome to use the scales available at the surgery if no other scales are available to you.

PLEASE TAKE YOUR BLOOD PRESSURE USING ONE OF THE MACHINES AVAILABLE AND RECORD IN THE BOX BELOW:

Smoking Status: *Please tick*: **Current** [ ] **Ex – smoker** [ ] **Never** [ ]
If you are a current smoker, how many per day (approx): ………………………………….

Alcohol (average units per week): ………………………………………………………………….

Summary Care Record: *Please tick:*
[ ] Yes – I wish to have a summary care record (you will not need to do anything more)

[ ] No – I do not wish to have a summary care record. If you have ticked no you will have to complete an “opt-out” form which you can collect from reception. (if you do not complete this form you will have been considered to have opted in)

You can get more information about the summary care record from reception. Please ask.

Occasionally it may be necessary for the surgery to contact you by telephone, for example to change an appointment you have booked or pass on a message from the doctor. We would like to ask if you would be happy for us to leave a message with a third party or on a voicemail if you are not available to take the call.

Please circle and then tick where appropriate and sign and date below:

I am / am not happy for you to leave a message on my:

Home phone [ ] Mobile phone [ ] 3rd Party [ ]

Signature: ………………………………………………………… Date: ………………………..

THIS ARRANGEMENT WILL REMAIN IN FORCE UNTIL YOU ADVISE US IN WRITING THAT YOU WISH TO CHANGE IT.

Please note:

We **DO NOT** automatically carry out “new patient health checks” at this surgery. If you feel you need to see / speak with a clinician please contact the surgery during opening times to arrange a suitable appointment.

Thank you for taking the time to complete this form

For office use only:

Usual GP: ………………………………………………… EMIS no: ………………………………………………….

ID seen (please state): …………………………….…… Date form handed in: ………………………….

Member of staff to check form: ………………………………….