## Rowan Tree PrActice

# REGISTRATION FORM

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| Today’s date: | | | | | | | |  | | | | | | | | | |
| PATIENT INFORMATION | | | | | | | | | | | | | | | | | |
| Patient’s last name: | | First: | | | Middle: | | | | ❑ Mr.  ❑ Mrs. | | ❑ Miss  ❑ Ms. | | Marital status (circle one) | | | | |
|  | | | | | | | | | Single / Mar / Div / Sep / Wid | | | | |
| Other Names if any: |  | | | | |  | | | | | Birth date: | | | | Age: | Sex: | |
|  |  | | | | |  | | | | | / / | | | |  | ❑ M | ❑ F |
| Street address: | | | | | | | City/Town: | | | | | | County: | | | | |
|  | | | | | | |  | | | | | |  | | | | |
| Post Code: | | | Email Address: | | | | | | | Home No: | | | | Mobile No: | | | |
|  | | |  | | | | | | |  | | | |  | | | |
| Previous Doctor details: | | | Previous address (if current is less than 3 years): | | | | | | | | | NHS Number (if known): | | | | | |
|  | | |  | | | | | | | | |  | | | | | |
| Chose surgery because referred to by (please check one box): | | | | | | | | | | | | | | | | | |
| Dr ❑ ❑ Family ❑ Friend ❑ Close to home/work ❑ Internet ❑Other | | | | | | | | | | | | | | | | | |
| Other family members seen here: | | | |  | | | | | | | | | | | | | |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | |  | | | | | | | | IN CASE OF EMERGENCY | | | | | | | | Next of Kin:- contact name and details: | | Relationship to patient: | | | Home phone | Mobile No: | |  | |  | | |  |  | | The above information is true and accurate to the best of my knowledge. | | | | | | | |  |  | |  |  | | |  | |  | Patient/Guardian signature | |  | Date | | |  | | | | | | | | | | | | | | | | | | |
| Ethnic Category | | | | | | | | | | | | | | | | | |
| |  |  |  | | --- | --- | --- | | White ❑ | White Irish ❑ | Other ❑ | | Mixed ❑ | W&B Caribbean ❑ | W&B African ❑ | | White & Asian ❑ | Asian Indian ❑ | Asian Pakistani ❑ | | Asian Bangladeshi ❑ | Other Asian ❑ | Black Caribbean ❑ | | Black African ❑ | Other Black ❑ | Other Ethnic ❑ | | | | | | | | | | | | | | | | | | |

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| PATIENT Medical INFORMATION | | | | | | | |
| Height Weight BP (if known) | | | | | | | |
| Are you currently a smoker? | | ❑ Yes ❑ No | | | | | |
| If so how many cigarettes/tobacco do you smoke per week: | |  | | | | | |
| Have you ever been a smoker? | | ❑ Yes ❑ No | | | | | |
| Do you drink alcohol? | | ❑ Yes ❑ No | | | | | |
| If yes – please complete the attached alcohol consumption questionnaire | | | | Completed ❑ Yes ❑ No | | | |
| Have you suffered from any of the following conditions:   |  |  |  | | --- | --- | --- | | Diabetes ❑ | Asthma ❑ | COPD ❑ | | Hypertension ❑ | Heart Disease ❑ | Stroke ❑ | | Epilepsy ❑ | Thyroid Disease ❑ | Cancer ❑ | | Depression ❑ | Other Mental Illness ❑ | Other ❑ |   If you have any of these conditions please make a review appointment when you register | | | | | | | |
| Have you ever had any other significant illnesses, if so when? | |  | | | | | |
| Have you ever had any operations, if so when? | |  | | | | | |
| Do you have any medical problems at present? | |  | | | | | |
| Please state any allergies or sensitivities you have: | |  | | | | | |
| Please list any tablets or medicines currently being taken: | |  | | | | | |
| **PATIENT MEDICAL INFORMATION** | | | | | | | |
| Are you able to administer your own medicines ❑ Yes ❑ No  If No please detail specific issues (e.g. difficulty in swallowing or opening bottles etc.) | | | | | | | |
| Please state any sensory impairment you have (i.e. Speech, Hearing, Sight, Other). Please give details: | | | | | | | |
| Please state any disabilities you would like us to be aware of | | | | | | | |
| Do you require the assistance of a Translator/Interpreter? | | Yes | | | No | | |
| Which language do you speak? | |  | | | | | |
| If you have a Carer, please state their Name/Address/Phone number:  Sign here if you wish us to disclose information about your health to your Carer:-  **Signed: Date:** | | | | | | | |
| Do you have a “living will”? ❑ 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: | | | | | | | |
| If you are on repeat medication please make an appointment with your Doctor to discuss your current prescription needs.  ❑ Yes ❑ No **DATE OF APPOINTMENT:** | | | | | | | |
| Would you like to register for Patient Access to book appointments online? ❑ Yes ❑ No | | | | | | | |
| Would you like to nominate a preferred Pharmacist for Electronic Prescription Service please provide details below:- | | | | | | | |
| Women Only | | | | | | | | |
| Date of last mammogram  (if over 50 or under regular surveillance): | Date: | |  | | | | | |
| Have you had a Hysterectomy? | Yes | | No | | | | Date | |
| Method of contraception |  | | | | | | | |
| Date of last smear test: |  | | | | | | | |
| What was the result of smear test (if known) | Was this at your GP’s Surgery | | | Yes | | No | | |

If you do not wish to have a cervical smear test please tick the box. We will make a note of your wishes on your medical records. If you choose not to have a smear test now, it does not mean that you cannot have them again in the future if you change your mind. If you have any queries or anxieties about having a cervical smear, do feel free to discuss these with our Practice Nurses. ❑

I am aware of the benefits of cervical screening but do not wish to have a cervical smear test done at present. I am also aware that I can change my mind about this at any time. ❑

**Signature:**

**Date:**

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| --- | --- | --- |
| Receptionist to Complete | | |
| Checked By: | Date: | Comments: |
| Signature: |  |  |

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| CHILD PATIENT INFORMATION FORM | | | | |
| Patient’s last name:  First: Middle: | ❑ Miss | ❑ Master | | |
| Any Delivery Problems? ❑ Yes ❑ No | Birth date: |  | Sex: | |
| / / |  | ❑ M | ❑ F |
| Was your child premature? ❑ Yes ❑ No | | | | |
| Has your child had any developmental checks, if so which ones: | | | | |
| Has your child had any diseases or operations? ❑ Yes ❑ No | | | | |
| What were these, when did they occur and did they need to be admitted to Hospital ❑ Yes ❑ No  Please give details: | | | | |
| Any allergies i.e.: Asthma/ Eczema/Other : ❑ Yes ❑ No  Please give details: | | | | |
| Any allergic/abnormal reactions to medications or vaccinations: ❑ Yes ❑ No  Please state: | | | | |
| Does your child have any medical problems at present: ❑ Yes ❑ No  Please state: | | | | |
| **CHILD PATIENT INFORMATION FORM** | | | | |
| Any disabilities or sensory impairment that you would like us to be aware of? ❑ Yes ❑ No | | | | |
| Please State: | | | | |
| Is your child currently taking prescribed medications? ❑ Yes ❑ No  If YES please list below: | | | | |
| Does your child have any significant family history of illness affecting their brothers, sisters, parents or grandparents: ❑ Yes ❑ No   |  |  |  | | --- | --- | --- | | Diabetes ❑ | Asthma ❑ | COPD ❑ | | Hypertension ❑ | Heart Disease ❑ | Stroke ❑ | | Epilepsy ❑ | Thyroid Disease ❑ | Cancer ❑ | | Depression ❑ | Other Mental Illness ❑ | Other ❑ | | | | | |

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| Children – 14 – 16 YEARS ONLY | | |
| Does your child smoke? | NO | YES (approx. how many per day) Please state: |
| Online Patient Access from 16 Years? |  |  |

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| CHILDREN CONTACT IN CASE OF EMERGENCY | | | | | | |
| Next of Kin:- contact name and details: | | Relationship to patient: | | Home phone | | Mobile No: |
| Parent | | Guardian | | Foster Carer | | Other |
| The above information is true and accurate to the best of my knowledge. | | | | | | |
|  |  | |  | |  | |
|  | Patient/Guardian signature | |  | | Date | |

**PLEASE ADD DATES WHEN VACCINATIONS WERE GIVEN:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **CHILD REGISTRATION FORM – PERSONAL IMMUNISATION RECORD** | | | | | | | |
| **VACCINATION** | **1st Dose** | **2nd Dose** | **3rd Dose** | **Other** | **Pre-School** | **Booster** | **Given in UK or Elsewhere?**  **Please state:** |
|  |  |  |  |  |  |  |  |
| **Pertussis** (Whooping Cough)  Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Diptheria**  Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Tetanus**  Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Hib**  Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Polio**  Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Pneumococcal**  Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Men C**  Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Hib MenC**  Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Rotavirus**  Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Influenza**  Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Meningitis B**  Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **MMR**  Measles  Mumps  Rubella | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **BCG**  Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Hep A**  Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **Hep B**  Date: | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |
| **HPV**  **Date:** | ❑ | ❑ | ❑ | ❑ | ❑ | ❑ |  |