HIGHGATE MEDICAL CENTRE - NEW PATIENT REGISTRATION Updated July 2022

Under 18’s registration will **NOT** be accepted without a parent registered at the practice.

Please provide proof of address (bank statement/ tenancy agreement) and proof of ID (driver’s license/ passport/ VISA) along with your form or your registration will be incomplete and rejected

If there is any incorrect information completed on this form and we find out after we have accepted your registration, we will remove you from our practice list as this is considered as fraud.

|  |  |
| --- | --- |
| Full Name: |  |
| Date of Birth: |  |
| Address: |  |
| Gender: |  |
| Telephone Number: |  |
| Mobile Number: |  |
| E-mail Address: |  |
| Next of Kin (Name & Relation): |  |
| Next of Kin Contact Number: |  |
| Marital Status: |  |
| Occupation: |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Height: |  | | | Weight: |  | Religion: | |  |
| Main Spoken Language |  | | | Do you require an Interpreter |  |  | |  |
| Do you smoke? |  | | | If so, how many cigarettes / cigars / tobacco do you smoke in a week? |  | Do you drink alcohol?  (if so how much in a week) | |  |
| Ethnicity: | | | White (UK) | | White (Irish) | | White (Other) | |
| Caribbean | | | African | | Asian | | Other Mixed  Background | |
| Indian /  Brit Indian | | | Pakistani /  Brit Pakistani | | Bangladeshi / Brit Bangladeshi | | Other Asian  Background | |
| Other Black  Background | | | Chinese | | Other | | Ethnic Category  not stated | |
| Daily exercise: | | | | Light | Moderate | Heavy | | |
| Any past Medical History we should be aware of: | |  | | | | | | |
| Do you have any current Medical Problems: | |  | | | | | | |
| Are you on any regular Medication:  (If so please list them) | |  | | | | | | |
| Any Family Medical History we should be aware of? | |  | | | | | | |
| Do you have any allergies?  (If so please list them) | |  | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 | | | | |
| Please state any Sensory Impairment you have  (i.e. Speech, Hearing, Sight): | | | |  | | | | | | | |
| Are you an ‘Assistance Dog’ User? | | | |  | | | | | | | |
| Please state any Physical/ Mental disabilities you have: | | | |  | | | | | | | |
| Do you care for anyone?  Are you cared for?  If so please give details | | | |  | | | | | | | |
| PPG: We are committed to improving the services we provide, to do this it is vital that we hear from patients about their experiences and ideas for making services better. If you are interested in getting involved, please tick the box | | | | | | | | | |  | |
| ON-LINE ACCESS: To book appointments, order prescriptions and access on-line records, please tick the box if you want to be a part of this service | | | | | | | | | |  | |
| SMS: Do you consent for us to contact you via SMS? | | | | | | | | | |  | |
| **It is FRAUD to provide false details, you will be removed from the surgery if you provide any false information** | | | | | | | | | | | |
| Patient  Signature: |  | | | | | Signature on  behalf of Patient: | |  | | | |