

Pembroke Surgery

## New Patient Registration Form <5yrs

Today's Date:

Please complete this confidential questionnaire.

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

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

Full Name:		Date of Birth:
Mr / Mrs / Miss / Ms / Other.....		Home Number
Address and Postcode		Mobile Number:
		Work Number:
Email Address:		Next of Kin:
Gender:	Male:	Female:

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)	
Your Ethnic Origin: (select one)	White British		White Irish		White Other	
Black Caribbean	Black African		Mixed White/Caribbean		Mixed White/Asian	
Indian	Pakistani		Bangladeshi		Other Asian Background	
Other Black Background	Chinese		Mixed White/Black African		Other Ethnic Group (state)	
Your main or 1 <sup>st</sup> language Spoken / Understood: (select one)	English	Hindi	Gujurati	Urdu	Bengali	Punjabi
Polish	Ukrainian	French	German	Spanish	Other: (Please specify)	

<b>Your Medical Background:</b>			
<b>What illnesses have you had &amp; When?</b>			
<b>What operations have you had and When?</b>			
<b>Do you have any medical problems at present?</b>			
<b>Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)</b>			
<b>Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)</b>	Diabetes	Heart Attack	Heart attack under age of 60
	Breast Cancer		Asthma
	Thyroid Disorder		Any other important Family Illness?

<b>Specific Needs:</b>		
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 Physical disabilities you have:		
Please state any Mental disabilities you have:		
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:		
Please state any phobias you have:		
If you are a Carer, please state the name / address / phone number of the person you care for:	<u>Person Cared For Contact Details:</u>	
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.	<u>Carer Contact Details:</u>	
	<u>Signed:</u>	<u>Date:</u>
Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	Yes / No	<i>If "Yes", can you please bring a written copy of it in to the Surgery</i>
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	Yes / No	<i>If "Yes", can you please bring a written copy of it in to the Surgery please state their name / address / phone number:</i>

**THIS FORM IS TO IDENTIFY IF YOUR CHILD REQUIRES IMMUNISATION  
AGAINST TUBERCULOSIS (BCG)**

One form to be completed for every child/young person please. To be completed for all young persons aged under 16 years who are registering.

**This information WILL NOT be used for any other purpose.**

Has your child been immunised against Tuberculosis (BCG)? Please tick ✓ Yes  No

If **YES** please give the date of immunisation .....

Was the child born in the UK? ✓ Yes  No

If **NO** please **PRINT** the country where the child was born

.....

Were either of the child's parents born outside the UK? Please tick ✓ Yes  No

If **YES** please **PRINT** which country the parent/s was/were born in

.....

Were any of the child's grandparents born outside the UK? Please tick ✓ Yes  No

If **YES** please **PRINT** which country they were born in

.....

Has there been a case of TB in the family in the last 5 years ? Please tick ✓ Yes  No

If **YES** please confirm if your child was tested for TB at that time Yes  No

.....

**Health Visitor Registration Form**

Surname/Family Name.....Male/Female

First/Given Name.....Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_

Address.....

.....Postcode.....

Telephone Number..... Mobile.....

Email Address.....

Mother's First/Given Name.....

Mother's Surname..... Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_

Previous Address in UK (if applicable)

.....  
.....Postcode.....

Previous GP in UK.....

Surgery Name and Address (if known).....  
.....

**OR**

Date of Entry in UK \_\_\_/\_\_\_/\_\_\_\_\_ Country of Origin.....

Mother Tongue..... English Spoken? Y / N

**If your child has any ongoing illnesses or takes any medications on a regular basis please give details of these below.**

*Continue overleaf if required*

**Please also complete the immunisation information on the second page of this form.**

**This information will be passed onto the Health Visitor and they will make contact with you.**

## IMMUNISATION DETAILS

To enable the surgery to make sure your child's immunisation schedule is complete we need to know the precise dates of their immunisations: Please complete the following information

<u>Diphtheria/Pertussis/Tetanus/Hib/Polio</u>	<u>PCV</u>	<u>Meningitis C</u>	<u>Hepatitis B</u>
Date Given	Date Given	Date Given	Date Given
1 <sup>st</sup> Dose _____	_____	_____	_____
2 <sup>nd</sup> Dose _____	_____	_____	_____
3 <sup>rd</sup> Dose _____	_____	_____	_____
Booster (Diphtheria/Pertussis/Tetanus//Polio)	_____		
<u>MMR</u>	<u>BCG</u> (if given)		
1 <sup>st</sup> Dose _____	_____		
2 <sup>nd</sup> Dose _____			

As your child is newly registered with this GP practice please sign the Immunisation consent form below

### Childs details

Surname \_\_\_\_\_ First name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

I agree to have my child named above receive appointments for immunisations

Signature of Parent / Guardian \_\_\_\_\_ date \_\_\_\_\_

**NOTE** You can reconsider this agreement at any time. This Information will be held on computer within the Data Protection Act