The Pines Surgery - New Patient Application Form

Title		**Date of Birth**		
First Name		**Surname (Family Name)**		
Occupation		**Previous Surnames**		
Current Home Address		**Home Telephone Number**		
		Work Telephone Number		
		Mobile Telephone Number **Please note we will automatically register you for the SMS text message reminder service. Please tick NO if you do not wish to be registered for this service.**		
		NO		
Postcode		**NHS Number if known**		
Name and address of you previous GP/Practice		**Please tick here if you have never been registered with a GP**		
How long do you intend to live at your new address?		**Less than 6 months**		**More than 6 months**
If you are new to the UK please give date of entry				
Next of kin details		**Name**		
		Address		
		Telephone Number		
		Relationship		

Please tick which document you have provided as proof of your identify

Passport		**Photo Driving Licence**	
Birth Certificate		**Other (Please state)**	

Please tick which 2 documents you have provided as proof of your address

Utility Bill		**Official Letter**	
Bank Statement		**Other (Please state)**	

If you are new to the UK have you provided proof of UK residency?

Passport / Visa	**Yes**	**No**

Ethnic Origin - Please tick appropriate box - This information will help to plan services to meet the needs of all patients.

White	British		Irish		Other		Other White Background	
Black	Caribbean		African		Other		Other Black Background	
Asian	Indian		Pakistani		Bangladeshi		Other Asian Background	
Mixed	White and black Caribbean		White and black African		White and Asia		Other Mixed Background	
Other Ethnicity	Chinese		Other					
Ethnic Category Not Stated								

What is your first language?	

MEDICAL INFORMATION

SMOKING

Smoker - How many cigarettes smoked a day	Number	
Would you like help to stop smoking?	Yes	No
Past Smoker - When did you give up?	Date	
Never Smoked	Please Tick	

ALCOHOL INTAKE

Total number of units consumed in a week	

CARERS

Do you care for someone?	Yes	No
If yes please give details	Name	Relationship
Does someone care for you?	Yes	No
If yes please give details	Name	Relationship

HEIGHT AND WEIGHT

Height	
Weight	

MILITARY VETERANS

Have you ever served in the Armed Forces (Military Veteran)?	Yes	No
Are you a reservist within the Armed Forces?	Yes	No

What is your current occupation?	

Please list any serious illness, operations or disabilities YOU have

Details	Year

FAMILY HISTORY

Please tick if anyone in your close family (i.e. parents, brothers or sisters) have suffered from any of the following

	Relative	Age at onset		Relative	Age at onset
Angina			Eczema		
Asthma			Epilepsy		
Blindness / Glaucoma			Hayfever		
Breast Cancer			Heart Attack		
Other Cancer			High Blood Pressure		
COPD			Sickle Cell		
Depression			Stroke		
Diabetes			Thalassaemia		

MOBILITY

Are you housebound	Yes	No

ALLERGIES

Do you have any allergies?	Yes	No	Please give details
Are you allergic to any medication?	Yes	No	Please give details

CURRENT MEDICATION

Please list

Are you registered disabled?	Yes	No
Are you registered as Blind or Partially Sighted?	Yes	No

FOR PATIENTS UNDER 18 ONLY

Do you, or have you ever had a social worker involved with your family?	Yes	No
Name of current school attended		

OTHER INFORMATION

Would you be interested in receiving more information about our Patient Participation Group?	Yes	No

ONLINE SERVICES

Would you like to register for online services?	Yes	No