The Pines Surgery - New Patient Application Form

PART 1—TO BE COMPLETED BY ALL PATIENTS

Title			Date of Birth	
First Name			Surname (Family Name)	
Occupation (if applicable)			Previous Surnames (if applicable)	
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	
Name and address of your 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?								

PART 2—TO BE COMPLETED BY ALL PATIENTS

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
If you care for someone please ask Reception for a Carers Pack which contains help and support available to you.		

HEIGHT AND WEIGHT

Height	
Weight	

PART 3—TO BE COMPLETED BY PATIENTS 13 YRS & OVER

MEDICAL INFORMATION

Smoker - How many cigarettes smoked a day	Number
Past Smoker - When did you give up?	Date
Never Smoked	Please Tick

ALCOHOL INTAKE

Total number of units consumed in a week	

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?	

PART 4—TO BE COMPLETED BY ALL PATIENTS

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

PART 5—TO BE COMPLETED FOR ALL CHILDREN

IMMUNISATION RECORD

Routine Childhood Immunisations	Age Usually Given	Date Given	Please indicate if declined with reason
1st Diphtheria, tetanus , pertussis, polio and Hib	2 months		
Hepatitis B			
Meningitis B			
Rotavirus			
Pneumococcal (PCV)			
2nd Diphtheria, tetanus, pertussis, polio and Hib	3 months		
Hepatitis B			
Rotavirus			
3rd Diphtheria, tetanus, pertussis, polio and Hib	4 months		
Hepatitis B			
Meningitis B			
Pneumococcal (PCV)			
Hib/Men C (Menitorix)	Around 12m		
1st MMR (Measles, Mumps, Rubella)	Around 12m		
Pneumococcal (PCB) booster	Around 12m		
Meningitis C	Around 12m		
2nd MMR	3 years 4 months approx		
4th Diphtheria, tetanus, pertussis, polio (pre-school booster)			
Human Papillomavirus vaccine (HPV)	Females only 12-18yrs		
5th Diphtheria, tetanus, pertussis, polio (school leavers booster)	13-18yrs		

NON ROUTINE VACCINES	**Date Given**				
Mantoux test	Result:				
BCG					
Meningitis C					
Hib Booster (Haemophilias Influenza B)					
Hepatitis B & babies	1st	2nd	3rd	4th	5th
Other Vaccines received/ Other information :					

Childrens Immunisations Cont….

Aged UNDER 2 Neonatal hearing test	Yes Date:	No	Blood Spot Test	Yes Date:	No

PART 6—TO BE COMPLETED BY ALL PATIENTS

CURRENT MEDICATION

Please list

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

OTHER INFORMATION

Would you be interested in receiving more information about our Patient Participation Group?	**Yes**	**No**
If Yes please tick here to consent to us emailing you ☐	**Email address:**	

ONLINE SERVICES

Please complete the Application for Online Services form attached. You will be given a login and password and this will enable you to make appointments, request repeat prescriptions and view your medical records.

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		

The information you have provided on this New Patient Registration Form will be used for the purposes of setting up your registration with The Pines Surgery.

Please sign below to confirm that you consent to your data being used for this purpose.

Signed by Patient…… Dated ……

Print name: ……..

If signed on behalf of the patient please indicate your relationship:……

Please complete one form per Patient