WATTON MEDICAL PRACTICE
NEW PATIENT REGISTRATION FORM

Please complete this confidential questionnaire (one for each member of the family to be registered with the practice. (There is a separate registration form for children). Please complete in BLOCK CAPITALS and tick the boxes as appropriate. Please complete as much information as you can and please bring your passport or birth certificate to confirm your date of birth and entitlement to NHS treatment.

FULL NAME:	**HOME TELEPHONE NUMBER:**
TITLE: **Mr/Mrs/Miss/Ms/Other** (delete as applicable)	**MOBILE PHONE NUMBER:**
ADDRESS AND POSTCODE:	**WORK PHONE NUMBER:**
	E-MAIL ADDRESS:
DATE OF BIRTH:	**PREVIOUS/MOTHER'S SURNAME IF DIFFERENT:**
MARITAL STATUS:	**GENDER:** **MALE/FEMALE** (delete as applicable)

TOWN & COUNTRY OF BIRTH:

NAMES & AGES OF CHILDREN:

NHS NUMBER: (if known)

ELECTRONIC PRESCRIBING:

The Electronic Prescription Service gives you the chance to change how your GP sends your prescription to the place you choose to get your medicines or appliances from. If you would like to use this service, please tick which pharmacy you would like your prescriptions to be sent to:

☐ **Total Health** ☐ **Boots (Watton)**

☐ **Other (please specify)**

PREVIOUS ADDRESS & POSTCODE:

PREVIOUS DOCTOR'S NAME & ADDRESS:	**PREVIOUS DOCTOR'S TELEPHONE NO:**

IF APPLICABLE, DATE YOU FIRST CAME TO LIVE IN BRITAIN:

CAN WE USE YOUR MOBILE NUMBER FOR APPOINTMENT REMINDERS AND TO INVITE YOU TO THE RELEVANT CLINIC'S: **YES/NO** (delete as applicable)

YOUR HEIGHT:	Feet/inches Cm		**Your weight:**	Stones/lbs Kg
YOUR RELIGION:	C of E ☐	Jewish ☐	Other Christian (state) ☐	Catholic ☐
No religion ☐	Hindu ☐	Other religion ☐	Jehovah's Witness ☐	Buddhist ☐
Muslim ☐	Sikh ☐	**PLEASE STATE ANY RELIGIOUS OR CULTURAL NEEDS:**		
YOUR ETHNIC ORIGIN:	White (UK) ☐	White (Irish) ☐	White (Other) ☐	Afrian ☐
Other Mixed Background ☐	Indian/Brit Indian ☐	Other Black Background ☐	Other Asian Background ☐	
Pakistani/ Brit Pakistani ☐	Bangaldeshi/ Brit Bangladeshi ☐	Asian ☐	Chinese ☐	Other ☐
YOUR MAIN OR 1ST LANGUAGE SPOKEN OR UNDERSTOOD:	English ☐	Hindi ☐	Gujurati ☐	Polish ☐	Urdu
	Spanish ☐	Bengali/Sytheti ☐	Other (please specif ☐	Ukranian ☐	German ☐
	French ☐	**DO YOU REQUIRE THE HELP OF A TRANSLATOR/INTERPRETER** YES/NO (delete as applicable)			

SMOKING, ALCOHOL CONSUMPTION AND EXERCISE

ARE YOU CURRENTLY A SMOKER:	**YES/NO** (delete as applicable)
HOW MUCH DO YOU SMOKE IN A WEEK: (If you are a smoker and want to stop, please ask for information about local smoking cessation services)	**YES/NO** (delete as applicable)
HAVE YOU EVER BEEN A SMOKER?:	**YES/NO** (delete as applicable)

HOW MUCH ALCOHOL DO YOU DRINK IN A WEEK: (Units?)

(One unit = 1 small glass of wine, a single measure of spirits or half a pint of beer)

DO YOU HAVE ANY MEDICAL PROBLEMS AT PRESENT?:

PLEASE STATE ANY ALLERGIES AND SENSITIVITIES YOU HAVE:

PLEASE LIST ANY TABLETS, MEDICINES OR OTHER TREATMENT YOU ARE CURRENTLY TAKING (include dose & frequency) OR ATTACH A REPEAT PRESCRIPTION REQUEST

ARE THERE ANY SERIOUS DISEASES THAT AFFECT YOUR PARENTS, BROTHERS OR SISTER'S?:

Diabetes	Heart Attack	Heart attack under age of 50	Stroke
☐	☐	☐	☐
High Blood Pressure	Asthma	Breast Cancer	Thyroid Disorder
☐	☐	☐	☐

Any other important family illness *(please specify)*
☐

SPECIFIC NEEDS:
Please detail below any specific needs you have so that the Practice can ensure they are identified and accomodated by taking the appropriate action (ie, any physical or mental disabilities)

ARE YOU A CARER: **YES/NO**

IF YES, PLEASE GIVE THE NAME OF THE PERSON YOU ARE A CARER FOR:

ARE YOU AN 'ASSISTANCE DOG' USER?:

DO YOU HAVE A 'LIVING WILL' (a statement explaining what medical treatment you would not want in the future?): **YES/NO** (delete as applicable)

Patient Signature: **Date:**

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