Grange Farm Medical Centre

New Patient Registration Questionnaire Form (Under 16's)

Patient Details

Title	Mr / Miss / Ms / Other (delete as appropriate)		Address		
First Name					
Middle Name					
Surname			Home Tel. No		Preferred contact Yes/No
Date of Birth			Mobile Tel. No		Preferred contact Yes/No
NHS Number			Email address		

Ethnic Origin

White	British / Irish / Other (delete as appropriate) .....
Mixed	White & Black Caribbean / White & Black African / White & Asian / Other (delete as appropriate) .....
Asian or Asian British	Indian / Pakistani / Bangladeshi / Other (delete as appropriate) .....
Black or Black British	Caribbean / African / Other (delete as appropriate) .....
Chinese or other Ethnic Group	Chinese / Other (delete as appropriate) .....
I do not wish to specify my ethnic origin	

Spoken Language

Main Spoken Language	
Do you speak English	Yes / No (delete as appropriate)
Do you need an interpreter?	Yes / No (delete as appropriate)

About You

Are you originally from Abroad?	Yes / No (delete as appropriate)			If so, when did you arrive in the UK?	
Next of Kin (optional)				Relationship to you	
Next of Kin address				Next of kin contact Telephone number	
Who has Parental Responsibility for you?				Relationship to you	
Address of person with Parental Responsibility				Contact Telephone number	
Do you consent to receiving text messages to your mobile phone?				Yes / No (delete as appropriate)	
Do you consent to us contacting you via e-mail?				Yes / No (delete as appropriate)	
Would you like to register for on-line services / NHS App?				Yes / No (delete as appropriate)	
Have you received a copy of our leaflet about Record Sharing?				Yes / No (delete as appropriate)	
Are you a carer?	Yes / No (delete as appropriate)			Who do you care for?	
Are you a cared for?	Yes / No (delete as appropriate)	Who is your carer?	Carers Name		Carer's contact Tel No.

17a Tremayne Road, Bilborough
Nottingham, NG8 4HQ
Tel: 0115 896 5002

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Medical Centre

Nursery / School / College

Name of Nursery, School or College	Address of Nursery, School or College	Contact Telephone number of Nursery, School or College

Medical Questions about you

Do you have a 'red book'?	Yes / No (delete as appropriate) If yes please bring to the surgery so that we can enter your immunisations onto your medical record.			
If you do not have a red book do you know what immunisations you have had?	Yes / No (delete as appropriate)			
If yes, details	Please provide clear evidence of immunisations			
Do you have any known allergies?	Yes / No (delete as appropriate)			
If yes, details				
Do you consider yourself to have a disability?	Yes / No (delete as appropriate)			
If yes, details				
Are you a smoker? (Please tick appropriate box)	No Never			
	Ex-smoker		When did you quit?	
	Smoker		How many per day?	
Would you like help to stop smoking?	Yes / No (delete as appropriate)			

Patient Declaration

To the best of my knowledge, all the preceding answers and information provided are true and correct	
Signature	
Print Name	
If completed on behalf of the patient – Patients Name	
Date	

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