FOR OFFICE USE ONLY	
Proof of identification	PASSPORT ☐ DRIVING LICENCE ☐ OTHER(please state):
Proof of address	BANK STATEMENT ☐ UTILITY BILL ☐ OTHER(please state):
Checked by:	
Date registered:	

Contact and Demographic Details	
Title: Mr ☐ Mrs ☐ Miss☐ Ms ☐	**Surname:**
DOB:	**First name(s):**
NHS no (if known):	**Previous surname:**
Gender: Male ☐ Female ☐	**Town & country of birth:**
Home address:	
Home tel no:	**Work tel no:**
To help trace your medical records please fill out the following information as applicable	
Email address:	**Mobile no:**
By supplying your email address you consent to the practice contacting with information, invites, results etc.	By supplying your mobile number you consent to the practice contacting you with information, reminders etc via text message.
Ethnicity: WHITE ☐ BLACK AFRICAN ☐ BLACK CARIBBEAN ☐ INDIAN ☐ PAKISTANI ☐ CHINESE ☐ DECLINE TO STATE☐ OTHER(please state)☐	
Main spoken language:	
Previous address in the UK:	
Previous GP Practice while at previous address given above:	
Are you a current member of the armed forces?	Yes ☐ No ☐
Please note that written authorisation from the DMS must accompany this form if you are a current member of the armed forces.	
Patients from abroad	
If you are from abroad, your first UK address where you were registered with a GP:	
If previous a UK resident, date you left UK:	
Date you first came to the UK:	
Patients returning from the Armed Forces	
Address before enlisting:	
Enlistment date:	
Date of discharge:	

Family History					
		Relation			Relation
Coronary Heart Disease	☐		Stroke	☐	
Diabetes	☐		High blood pressure	☐	
Epilepsy	☐		Asthma	☐	
Hypothyroidism	☐		Cancer	☐	
Chronic Obstructive Pulmonary Disease	☐		Serious mental illness	☐	

About You	
Height:	**Weight**:
Known allergies:	
Are you an **unpaid** carer for someone?	Yes ☐ No ☐
Do you have a friend/relative who is your carer?	Yes ☐ No ☐
Please provide their name and address if applicable.	
If you are on any regular medication please attach a copy of your medication repeat ordering slip from your previous surgery.	

Next of Kin Details			
Name	**Relationship**	**Contact tel. no**	**DOB**
Are you happy for this person to be able to discuss your medical record with the practice?		YES ☐	NO ☐

About Your Lifestyle					
Do you smoke?	Yes ☐ No ☐				
If yes do you smoke (please tick)	CIGARETTES ☐ CIGARS ☐ PIPE ☐				
How many cigarettes/cigars do you smoke a day?	<1 ☐	1-9 ☐	10-19 ☐	20-39 ☐	40+ ☐
If you smoke a pipe, how many ounces per week?					
Are you an ex-smoker	Yes ☐ No ☐				
When did you give up?					

Communication Needs			
We're improving how we communicate with patients. Please indicate below if you require information in a different format or need communication support.			
I am deaf/hard of hearing	☐	I am blind/visually impaired	☐
I use a BSL interpreter	☐	I need information in large print format	☐
I use a communication advocate	☐	I need information in easy read format	☐
I lip read	☐	I need information in Braille	☐
Other communication needs (please specify):			

Data Sharing Consent
Please read the accompanying patient information leaflet regarding data sharing for information on how your data is used and how to record a decision to opt out of the various data sharing schemes.