**St. George’s Crescent Surgery**

**New Patient Registration Questionnaire**

**Please complete this form in black ink and tick the boxes which are applicable.**

Do you require this form in larger print? Yes No

Are you classified as having a disability? Yes No

If yes, please state the disability................................................................................................................

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Title: Dr / Mr / Mrs / Ms / Miss (please delete as required)    Forename: ................................................................  Surname: ..................................................................  Address: .................................................................... ..................................................................................  ..................................................................................  ..................................................................................  Postcode: ..................................................................    Home Phone Number: ..............................................  Mobile Number: .......................................................  Work Number (if applicable): ................................... Email: ....................................................................... | |  | | --- | |  |     Marital Status: Married   |  | | --- | |  |   Single   |  | | --- | |  |   Divorced   |  | | --- | |  |   Co Habit   |  | | --- | |  |   Widowed |
| Date of Birth: .............../........../.......... |
| |  | | --- | |  |     Dependants: Yes No    If yes, how many: ..............................................  Next of Kin: .........................................................  Relationship to Yourself: ....................................  Contact Number: ................................................ |
| |  | | --- | |  |     Have you been registered at this Practice previously? Yes No   |  | | --- | |  |     Do you reside with anyone registered at this Practice: Yes No    If so give details: ....................................................................................................................................... | |
| **Carer’s** | |
| |  |  |  | | --- | --- | --- | |  | No |  |     Are you a carer Yes    Name & Date of Birth of the person/person’s you care for, if they are registered at this Practice:  ..................................................................................................................................................................   |  | | --- | |  |     Are you being cared for? Yes No    Please state the name & address of your carer  ..................................................................................................................................................................  .................................................................................................................................................................. | |
| **Patient’s Health Style Questionnaire** | |
| |  | | --- | |  |     **Smoking Status**: Never Smoked    Stopped Smoking When?....................................................   |  | | --- | |  |   Smoker How many a day?...................................  How many years?...................................      **Alcohol Consumption**: E.g. ½ pint of beer = 1-unit 125ml Glass of wine = 1 unit    Drinks Alcohol Yes How many units do you drink per week?............................................     |  | | --- | |  |   No   |  | | --- | |  |   Lifetime Teetotaller Yes   |  | | --- | |  |   No    **Height**: ................................................................ **Weight:** ........................................................... | |
| Please remember that all sections of this form need to be completed.    If registering any children aged 5 and under, you will need to bring in their ‘Red Book/Child Health Record’ or a complete copy of previous immunisations (you can obtain a copy of this from your previous G.P Practice) before the registration can be processed. | |