**New Patient Registration Form**

***As part of our new care navigator scheme our practice team have been trained to assist you to seethe right person to meet your needs, by asking about your reasons for wanting to see a GP.***

***The 'Care Navigator' who takes your call will ask you a few questions to assess your care needs. This will enable them to direct you to the most appropriate person or service, which may not always be a GP; it may be a nurse or a pharmacist. Your call is always in the strictest confidence.***

***Our GP's are asking patients try and assist our 'Care navigators' as much as they can, so we can supports patients access to the right care in the right setting as quickly as possible.***

**Surname:** …… **First Name(s):** ……

**Date of Birth:** / / **Occupation:** ……

**Address:** ……

…… **Post Code:** ……

**Home Tel No:** …… **Mobile Tel No:** ……

**Email:** ……

PLEASE BE AWARE THAT UNSWORT H MEDICAL CENTRE MAY SEND NOTIFICATONS BY WAY OF SMS TEXT MESSAGES. PLEASE ENSURE YOU ADVISE UNSWORTH MEDICAL CENTRE SHOULD YOU CHANGE YOU CONTACT NUMBERS AT ANY TIME.

**Please list anyone living at the above address:** ……

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**Next of Kin Name:** ……

**Address:** ……

…… **Post Code:** ……

**Home Tel No:** …… **Mobile Tel No:** ……

**Ethnic Origin** Please tick as appropriate

**White**

- ☐ British/Mixed British
- ☐ Irish
- ☐ Other (please state):
- ☐ Other European origin (please state):

**Black or Black British**

- ☐ Caribbean
- ☐ African
- ☐ Other black background (please state):

**Asian or Asian British**

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Other Asian background (please state)

**Mixed**

- ☐ White & Black Caribbean
- ☐ White & Black African
- ☐ White & Asian
- ☐ Other (please state):

**Chinese or other Ethnic Group**

- ☐ Chinese
- ☐ Other (please state):

**Main language spoken:** ……

**Dialect:** ……

**Do you need an interpreter? YES / NO**

## Children (Under 16 years of age)

**Birth weight:** …… **Which school do you attend?** ……

**Please list any previous illness's:** ……

## Adults (over 16 years of age)

**Height:** …… **Weight:** ……..

**Do you have any allergies?** ……

**Do you take regular exercise?** ……

**Smoking History:**

- ☐ Never smoked tobacco
- ☐ Ex-smoker
- ☐ Current smoker

**Do you drink alcohol?**

- ☐ Yes
- ☐ No

**If yes how many units per week?** ……

**Smoking Cessation Advice available, please ask at Reception**

**When was your last tetanus?** ……..

**Please list any previous illnesses:**

- ☐ ASTHMA
- ☐ HEART DISEASE
- ☐ DIABETES
- ☐ COPD
- ☐ MENTAL HEALTH ISSUES
- ☐ OTHER (please state below)

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**Are you a carer or does somebody care for you? YES / NO**

IF YES PLEASE ASK AT RECEPTION FOR A CARERS FORM, TO REGISTER FOR A CARERS HEALTH CHECK

**Are you a military veteran? YES / NO**

IF YES WHICH ARMED FORCE? ……

ARE YOU HAPPY FOR US TO PUT A NOTE ON YOUR MEDICAL RECORDS? YES / NO

ARE YOU HAPPY FOR US TO SHARE THIS WITH OTHER HEALTH CARE PROFESSIONALS? YES / NO