**ST. DAVID’S CLINIC**

**NEW PATIENT REGISTRATION**

***When registering your application to join our Practice we will not discriminate on grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical conditions.***

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| **SURNAME:** | **FORENAME:** |
| **DATE OF BIRTH:** **Please tick if under 16:**  | **NHS:** |
| **If you have recently entered the UK and not yet registered with a GP please provide the date you first came to live in the UK:** |  |
| **ADDRESS:*****\*Please note we cannot proceed with your registration without proof of address. Bank Statement, Utility Bill or Tenancy Agreement:******If you do not possess this information due to no fixed abode please tick here (#13D.11)*** | **CONTACT DETAILS:**Mobile:Home:Email: |
| **\*Please tick box if you are happy to be contacted via email/text by the surgery for results, appointments etc.**  |
| **Please tick if refugee/asylum seeker status:****If Yes please enter the date entered the UK:** | **Yes No:****………………………………………….** |

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| **Please indicate your ethnic origin**:  |
| **Do you need an interpreter and if so what language? Yes No**  |

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| Do you smoke? Yes No  |
| If so how many per day? |  |

St David’s is committed to assisting our patients to give up smoking through Cessation Clinic and medication. **Would you like any further advice or help? YES NO**

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| --- | --- |
| How much alcohol do you drink a week?(1 pint of beer equals 2 units)(1 glass of wine equals 1 unit)(1 short measure equals 1 unit) |  |

|  |  |
| --- | --- |
| Height: | Weight: |

|  |  |
| --- | --- |
| What is your medical history? |  |

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| **MEDICATION**If you are prescribed regular medication, please provide your repeat slip. **Repeat slips can be obtained from your previous surgery.**  **If this is not** **provided it may delay your medication.**If this is not possible please list all medication you are currently taking including dosage and frequency, (this includes oxygen).***Please COMPLETE THE TICK BOX if you are taking warfarin AS YOU WILL BE REQUIRED TO ATTEND THE SURGERY FOR INR MONITORING*** | **Warfarin**  |

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| **FAMILY HISTORY:** *Please tell us about your immediate family. Any illness such as heart disease, stroke, blood pressure, asthma or diabetes* |
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| Are you a carer? | YES NO  |
| Are you a veteran? | yes no  |

|  |  |
| --- | --- |
| **FEMALE PATIENTS****ONLY** | Last date of smear and result: |
| Are you using any form of contraception: YES NO |
| Type: |
| When/Where fitted (if coil or implant): |

|  |  |
| --- | --- |
| **REGISTRATION OF CHILDREN:**Please provide details of the child’s parents/guardian | Name:Relationship:Name:Relationship: |
| **Please provide any immunisation information if you can: (child will have a red book, please bring this along so we can take a copy of this)** |  |

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| **SIGNED:** | **DATE:** |

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| **OFFICE USE ONLY:****Proof of address type:****Staff name:****Date:****\*CODE FOR TEXT MESSAGE DECLINES #9NdQ.00** |