

ADULT REGISTRATION FORM

TITLE..... SURNAME/FAMILY NAME.....

FORENAMES

MAIDEN / FORMER NAME.....

DATE OF BIRTH..... NHS NO (IF KNOWN).....

GENDER: Male Female Other.....

ETHNICITY (please tick):

WHITE - BRITISH	<input type="checkbox"/>	ASIAN OR ASIAN BRITISH - INDIAN	<input type="checkbox"/>
WHITE - IRISH	<input type="checkbox"/>	ASIAN OR ASIAN BRITISH - PAKISTANI	<input type="checkbox"/>
WHITE - OTHER	<input type="checkbox"/>	ASIAN OR ASIAN BRITISH - BANGLADESHI	<input type="checkbox"/>
MIXED - WHITE AND BLACK CARIBBEAN	<input type="checkbox"/>	ASIAN OR ASIAN BRITISH - OTHER ASIAN BACKGROUND	<input type="checkbox"/>
MIXED - WHITE AND BLACK AFRICAN	<input type="checkbox"/>	BLACK OR BLACK BRITISH - CARIBBEAN	<input type="checkbox"/>
MIXED - WHITE AND ASIAN	<input type="checkbox"/>	BLACK OR BLACK BRITISH - AFRICAN	<input type="checkbox"/>
MIXED - OTHER MIXED GROUPS	<input type="checkbox"/>	BLACK OR BLACK BRITISH - OTHER BLACK BACKGROUND	<input type="checkbox"/>
ANY OTHER ETHNIC GROUP	<input type="checkbox"/>	CHINESE	<input type="checkbox"/>
NOT STATED/ RATHER NOT ANSWER			<input type="checkbox"/>

TOWN/COUNTRY OF BIRTH.....

IF FROM OVERSEAS, DATE OF ENTRY TO THE UK.....

MAIN LANGUAGE.....INTERPRETER REQUIRED YES NO

HOME ADDRESS.....

POSTCODE..... EMAIL ADDRESS.....

TELEPHONE NUMBERS HOME..... MOBILE.....

PREVIOUS ADDRESS

PREVIOUS GP PRACTICE.....

NEXT OF KIN, NAME.....PHONE NO.....

HEIGHT..... WEIGHT.....

SMOKING: Do you smoke? Yes No Ex-Smoker
 Cigarettes Cigars Pipe Vape How many per day?

ALCOHOL: Do you drink alcohol? Yes No How much per week?

MEDICATION: Please give full details of any tablets/medications taken regularly and please bring your repeat prescription slip from your previous doctor with you when returning this form so that we can photocopy it

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Do you suffer from any ALLERGIES TO MEDICINES? Yes No

Details.....
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Please complete the following:

I do do not give permission for my prescriptions to be collected by a member of my family.

I do do not give permission for messages to be left on my telephone for me.

I consent for the following person (carer/family member) to have access to my medical records and deal with repeat prescriptions / test results / referrals / medical advice.

Carer/Family Member's Name

Patient's signature Date.....

DATA SHARING

To enable other NHS Healthcare Organisations to administer any treatment safely, they need to be aware of your current medications, allergies and adverse reactions. By default this information will be shared with them by us. If you DO NOT wish for this information (Summary Care Record) to be shared, please complete the following:

I DO NOT wish for my Summary Care Record to be shared

Signed..... Date

Additional patient data from GP Medical Records is used every day to improve health, care and services through planning and research. Any data that NHS Digital collects in this way will only be used for health and care purposes. It is never shared with marketing or insurance companies. If you DO NOT want your patient data shared with NHS Digital please contact 0300 303 5678 or complete the online form via YOUR NHS MATTERS

[\(www.nhs.uk/your-nhs-data-matters/manage-your-choice/\)](http://www.nhs.uk/your-nhs-data-matters/manage-your-choice/)