

**MOUNTSANDEL REGISTRATION FORM**

**Please note, we are unable to accept incomplete forms or forms without correct supporting I.D.**

**A GUIDE TO PAPERWORK REQUIRED TO REGISTER**

**SUPPORTING DOCUMENTS:**

1. PHOTOGRAPHIC ID (Passport, Driving Licence, Electoral Card, Bus Pass, Police approved ID) these should be the original documents.
2. LAWFULNESS – Passport, Birth Certificate other documents listed – these should be the original document.
3. PROOF OF ADDRESS (Utility bill, tenancy agreement (not handwritten), bank statement **showing activity** – account number and amounts can be blacked out, rates bill - junk mail cannot be accepted) **ALL PROOF OF ADDRESS DOCUMENTS MUST BE DATED WITHIN THE LAST 3 MONTHS**
4. Please check the forms for any other relevant identification required

***IF YOU ARE ON MEDICATION IT IS YOUR RESPONSIBILY TO GET A COPY OF THIS INFORMATION FROM YOUR PREVIOUS PRACTICE.***

****

**\*\* ALL PAPERWORK MUST BE RETURNED TOGETHER, AT THE SAME TIME, WITH CORRECT I.D. OR WE WILL NOT BE ABLE TO ACCEPT FORMS. Thank you.**



**MOUNTSANDEL REGISTRATION FORM**

***Please complete entire form or we cannot accept it***

**SECTION A: PATIENT DETAILS**

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Forename(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: Mr/Mrs/Miss/Ms/Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

Known as: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male / Female \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Tel No: \_\_\_\_\_\_\_\_\_\_\_\_ Mobile No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work No: \_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you: \_\_\_\_\_\_\_\_\_\_ Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Text Messaging:** Are you happy for the Practice to communicate with you by email or text message: **YES □ NO □**

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**SECTION B: CURRENT MEDICATION:**

Are you currently on any regular medication? **YES □ NO □**

***If YES, please provide a printout summary from your previous GP when returning this form or we may be unable to prescribe your medication.***

**Please also list your current medication below:**

|  |  |  |
| --- | --- | --- |
| **NAME OF DRUG** | **STRENGTH** | **DOSE** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Known Allergies**

Do you suffer from any known allergies? **YES □ NO □**

**Please list all of your allergies below:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**MOUNTSANDEL REGISTRATION FORM**

**SECTION C:**

**Carer Status**

Are you a Carer? *(#918A)* **YES □ NO □**

**PAST MEDICAL HISTORY**  (*ie. Operations/Illnesses*) please give brief details below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** *Please circle where appropriate and state relationship & age*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Heart Attack/Angina | Yes / No | Relationship: |  | Age of Onset: |  |
| Stroke | Yes / No | Relationship: |  | Age of Onset: |  |
| Hypertension | Yes / No | Relationship: |  | Age of Onset: |  |
| Diabetes | Yes / No | Relationship: |  | Age of Onset |  |
| Breast Cancer | Yes / No | Relationship: |  | Age of Onset: |  |
| Bowel Cancer | Yes / No | Relationship: |  | Age of Onset: |  |

**HEALTH PROMOTION**:

* Smoking Status: **Never Smoked □ Ex-Smoker □ Current Smoker □**

*If current smoker,* ***how many do you smoke per day?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* Do you drink alcohol: Y**ES / NO Units per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***(1 Pint beer = 2 units; 1 glass wine = 1 unit; 1 measure spirits 1.5 units)***

* Exercise: Do you take regular exercise: **YES / NO**

Type of exercise - Is it: **GENTLE / VIGOROUS / MODERATE / INACTIVE**

**ETHNIC ORIGIN:** *(Please tick one box!)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| British |  | Other White |  | Bangladeshi |  |
| Black African |  | Black Carribean |  | Black Other Mixed |  |
| Chinese |  | Indian |  | Pakistani |  |
| Other (*please state)*: |  |  |  |  |  |



**MOUNTSANDEL REGISTRATION FORM**

**SECTION D:**

Name and address of Previous Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Changing Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been registered at this Practice before?  **YES □ NO □**

Your **Previous** Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postcode: \_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**SECTION E: - *TO BE COMPLETED BY FOREIGN NATIONALS ONLY***

Is English your first language? **YES □ NO □**

What is your preferred first language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(#13ZA000)**

Do you require the services of an Interpreter? **(#9NU0)** **YES □ NO □**

What is your Nationality? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Next of Kin in your Home Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION E: - *TO BE COMPLETED BY ASYLUM SEEKERS ONLY***

If you are an asylum seek, please tick here: **□ (#13ZN)**

If you have a caseworker, please provide contact details: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organisation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

**SECTION F: - PATIENT SIGNATURE**

I can confirm that the information that I have provided is accurate and true.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***.***

**-------------------------------------------------------------------------------------------------------------------**

***FOR OFFICE USE ONLY****:*

Patient identified and checked against I.D.:  **YES □**

\***Staff Member Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appproved By GP: **GP Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**