The Weavers Practice

New Patient Registration Form

Please take some time to read through our practice leaflet before you fill this form in. It would be helpful if you could provide us with as much information as possible by answering the questions below to help us provide you with the most appropriate care until we receive your medical records from your previous practice.

If you wish to apply for online access, Photographic I.D and proof of address (within the last 3 months) will be required.

IT IS YOUR RESPONSIBILITY TO INFORM US OF ANY ADDRESS OR TELEPHONE NUMBER CHANGES

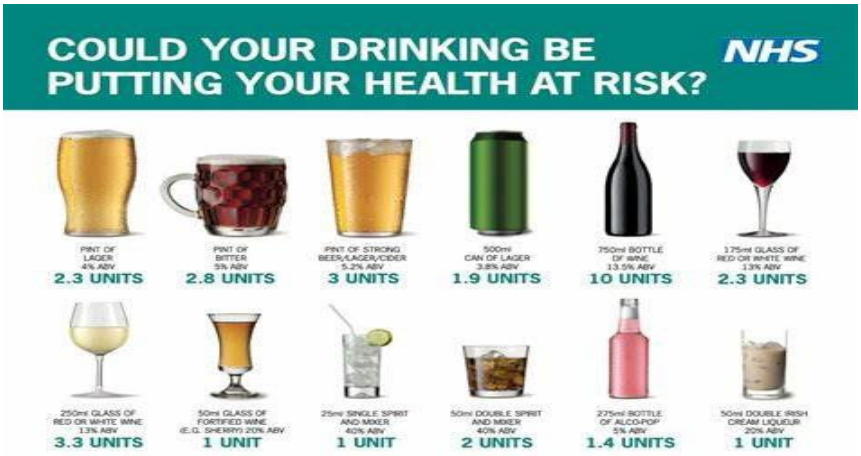
Patient registration and health questionnaire

Title: (Mr, Mrs, etc.)		**Date of birth**	
Forename(s)			
Surname		**Previous surname**	
Calling name		**Occupation**	
Current address			
Home phone number		**Mobile phone number**	
Email address			
NHS number			
Previous address			
Previous GP			
Have you been registered here previously? If yes, please give dates.			
Have you moved to the UK from abroad? If yes, give date of arrival in the UK.			
Next of kin details: **Title:** **Surname:** **Forename:** **Relationship:** **Address:** **Telephone numbers:**			

Armed Forces veterans' service: **Dates of service:** **Discharge date:** **Address prior to serving:**	
Special circumstances:	Please tick if any of the following apply: I have a carer I am a carer Asylum seeker Housebound Live in a nursing home Live in a residential home Live in a community psychiatric home Live in a children's home

Height		**Weight**	
Allergies		**Disabilities**	

Are you: **Registered blind or partially sighted** **Registered deaf** **Registered disabled**	Please state which of these apply:
Please state your ethnicity	
Do you have any drug allergies? ***Please include known reactions***	
Do you have any other allergies? ***Please give as much detail as possible***	
Do you suffer from any of the following: **Heart disease** **Hypertension** **Asthma** **Diabetes** **COPD** **Chronic kidney disease** **Epilepsy** **Stroke** **Cancer**	Please state which of these apply and give date of last review:
Do you have any other serious or chronic illness?	Please explain:

Do you have a family history of: **Diabetes** **Heart disease** **High cholesterol** **Heart attack** **Stroke** **Cancer**	Please give details, including relationship, illness and age at diagnosis, if known:
Have you had any significant injuries or major operations?	If yes, please give details:
Smoking status – Are you: **A current smoker** **An ex-smoker** **A non-smoker**	If a current or ex-smoker, please give details of how many you smoke or smoked per day. If you are an ex-smoker, please give the date you stopped (month/year).
Electronic cigarette user?	
Smoking cessation advice is available. Would you like further information?	If yes, please ask at reception or see our website for details.
Alcohol units consumed per week?	

Alcohol scoring system	0	1	2	3	4	Score
How often do you drink alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when drinking?	1-2	3-4	5-6	7-9	10+	
How often have you drunk more than 8 units (men) or 6 units (women) on a single occasion in the past year?	Never	Less often than monthly	Monthly	Weekly	Daily or almost daily	
Advice is available if you would like to reduce your alcohol intake	Please ask at reception or see our website for details.					

Current medication	If possible, attach a copy of your repeat prescription list.			
Medication	Dosage	Repeat	Quantity remaining	

If you have a nominated pharmacy, please tell us here:

NAME OF PHARMACY:

Immunisations

Please consult your Red Book for dates

NAME OF IMMUNISATION	AGE WHEN NORMALLY GIVEN	DATE RECEIVED
Diphtheria, tetanus, whooping cough polio and Hib	8 weeks	
Pneumococcal	8 weeks	
Rotavirus	8 weeks	
Meningococcal (Men C)	12 weeks	
Rotavirus booster	12 weeks	
Diptheria, tetanus, whooping cough polio and Hib booster	16 weeks	
Pneumococcal booster	16 weeks	
Hib, Men C booster	1 year	
Pneumococcal booster	1 year	
Mumps, measles, and rubella (MMR)	1 year	
Diptheria, tetanus, whooping cough polio booster	From 3 years 4 months (pre-school booster)	

Mumps, measles, and rubella (MMR) booster	From 3 years 4 months (pre-school booster)	
Additional Information		

Females only:	
Date of last cervical smear	
Contraception used	
Please use this space to give any other information you feel is appropriate:	
PATIENT DECLARATION	
I confirm that, to the best of my knowledge, the information I have provided is accurate and correct.	
Signature	
Print name	
Date	

Summary Care Record:

Your Summary Care Record (SCR) is a copy of key information held in your GP records. This provides authorised healthcare staff with secure access to essential information about you and is used when you need unplanned care or when your GP surgery is closed. For more information, please see the attached leaflet or visit: **www.digital.nhs.uk/summary-care-records**

Please tick one of the boxes below with your preference:

- ❑ Express consent for medication, allergies, and adverse reactions only.
- ❑ Express consent for medication, allergies, adverse reactions, AND additional information – please see attached leaflet for more information.
- ❑ Express dissent (opt out) – I do not want a summary care record

Practice Communications:

We use your registered email address and mobile number to communicate with you via email or text message. Please select your preferred method of contact below:

- ❑ **SMS**
- ❑ **Email**
- ❑ **None of the above (Opt Out)**

Please note that it is your responsibility to inform us of any changes to your contact details.

For office use only:

Date form Received		Form completed in Full	YES NO
Received and checked by			
Additional Comments			

Updated September 2023