Devonshire Green and Hanover Medical Centres

Dr K Brown♦ Dr E Allsopp ♦ Dr H Briddon ♦ Dr A O'Rourke

NEW PATIENTS - please complete this form when you register with the practice

Surname……………………………………………Forename(s)……………………………………………

Date of birth ………………………………Place of Birth ……….……………………………………..

Address………………………………………………………………………………………………..

……………………………………………………………………………..Post code………..............

Daytime Telephone Number …………………………………Mobile…. ………………………………

Dependent Children: Do you have dependent children? No / Yes If Yes, how many:…………

IMPORTANT: Children must be seen by a Nurse or Doctor before being registered. Please provide their Immunisation history on their first consultation

Smoking - Do you smoke?

☐ No ☐ Never Smoked ☐ No –stopped smoking on (date) ………………

☐ Yes ☐ Cigarettes ☐ Cigars How many per day? ....

☐ Pipe …………. oz / grams per day

Pregnancy - Are you pregnant? No / Yes * Expected date of delivery (EDD): ……………

**You should make an appointment with a doctor, if you are Pregnant or will need a further supply of Medication.*

Carer - ☐ Please tick the box if you look after someone who is ill, frail, disabled, mentally ill, or has learning difficulties. (*The surgery can put you in touch with agencies which offer support for carers. Please ask reception for a Carers Identification and Referral Form)*

Contact in case of an emergency: Name………………………… Telephone no …………………..

Address………………………………………………………………………………………………

………

Relationship to you…………………………………………..…..

Ethnic Group: Please tick appropriately

White	☐ White British	☐ White Irish	☐ Other white European
	☐ Other white background		
Mixed	☐ Mixed Caribbean	☐ Mixed African	☐ Mixed Asian
	☐ Other mixed background		
Asian or Asian British		☐ Indian	☐ Pakistani
	☐ Bangladeshi	☐ Other Asian background	
Black or Black British		☐ Caribbean	☐ African
	☐ Somali	☐ Other black background	
Other Ethnic Group		☐ Chinese	☐ Japanese
	☐ Other group - ______________________		

*** First Language (if not English) ………………………………………………**

Please continue overleaf

Your Alcohol Intake: Please give a score 0 - 4 for each of the three questions, then total these.

Questions	Score **0**	Score **1**	Score **2**	Score **3**	Score **4**	**Your Score**
1. How often do you have a drink that contains alcohol?	Never	Monthly or less	2–4 times per month	2-3 times per week	4+ times per week	
2. How many standard alcoholic units do you have on a typical day when you are drinking? *(see table below)*	1 – 2	3 – 4	5 – 6	7 – 9	10+	
3. How often do you have 6 or more standard alcohol units on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					TOTAL SCORE =	

For your guidance on what is a unit of alcohol -

I confirm that I **agree/do not agree** (delete as appropriate) to Devonshire Green and Hanover Medical Centres may contact me on the mobile telephone number provided and that this number belongs only to me.

Please sign ________________________________

I confirm that **I agree/do not agree** (delete as appropriate**)** that Devonshire Green and Hanover Medical Centres may use the mobile telephone number provided to send texts to you, for example: appointment reminders and any appropriate practice health campaigns and results of investigations.

Please sign ________________________________

I confirm that the above information is correct at the date of signing this records and that should my details change that I will inform the practice as soon as possible.

Please sign ________________________________ Date ________________________________

Print Name ________________________________

It is occasionally helpful to contact your previous GP regarding your medical history if your records are incomplete or take a long time to arrive at the surgery.

Please tick this box ☐ **if you ARE NOT happy for us to contact your previous GP**

Please return completed form to reception at the Medical Centre.