

Additional Registration Details

Your contact details:

First Name: _____ Surname: _____
 Date of Birth: _____ Previous Surname(s): _____
 Occupation: _____ Home Address: _____
 Mobile Tel: _____
 Home Tel: _____
 Work Tel: _____
 Email: _____ Post Code: _____
 What is your first language? _____

Ethnic Group

White	Asian, Asian British	Caribbean or Black	African
British <input type="checkbox"/>	Pakistani, Pakistani British <input type="checkbox"/>	Caribbean, Caribbean British <input type="checkbox"/>	African, African British <input type="checkbox"/>
Irish <input type="checkbox"/>	Indian, Indian British <input type="checkbox"/>	Black, Black British <input type="checkbox"/>	
Polish <input type="checkbox"/>	Bangladeshi, Bangladeshi British <input type="checkbox"/>		
	Chinese, Chinese British <input type="checkbox"/>		
Mixed or multiple ethnic group: _____			
Other, please specify: _____			
If you would prefer not to specify this information please tick here <input type="checkbox"/>			

Free Texting Service (Please do not forget to inform us if your details change)

Please fill out details below if you would like to receive text message reminders for your appointments, and general health campaigns by email.

Mobile Number: _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Please tick if you would be happy for us to leave a message on your answer machine: _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
Email Address: _____	YES <input type="checkbox"/> NO <input type="checkbox"/>

At The James Cochrane Practice, patient confidentiality is of the greatest importance to us, you can be assured that the system we use is controlled by a highly secure network. Details will not be passed on to third parties.
 You can expect to receive text reminders for appointments, practice information, notification of specific health campaigns, & general health promotion. Potentially this may be extended to include notification of lab results. This is an all-inclusive service; you are consenting to receive all information types outlined above.

Next of Kin Please give name, address and telephone number of your next of kin.

Name: _____	Relationship: _____
Address: _____	Telephone Number: _____

Emergency Contact Please give name, address and telephone number of your next of kin.

Name: _____	Relationship: _____
Address: _____	Telephone Number: _____

Carers

Do you have a carer? (If yes please give details) YES NO

Are you a carer? (If yes please give details) YES NO

If you have any communication needs e.g. large font letters/ interpreter, please advise below

Medical Information

Please list any serious illnesses/ operations/ accidents/ disabilities (and for women any pregnancy related problems) and the year they took place:

Please list any medicines being taken and the amount:

Are you allergic to anything including medicines and if so which ones YES NO

Prescriptions

This practice issues electronic prescriptions, therefore no paper ones are issued.

Please circle a nominated pharmacy you would like your prescription to be sent to:

Well Helme Chase	Asda Pharmacy	Rowlands	Well Highgate
Boots Pharmacy	Superdrug Pharmacy	Well Maude Street	Lloyds Pharmacy
Staveley Pharmacy	If other please specify:		

The practice dispenses medicines to patients who live in the rural areas and are more than a mile away from a pharmacy. Medication is dispensed at the Helme Chase Surgery, and collected from either site.

Family History

Disease or Illness	Which Relation?	Disease or Illness	Which Relation?
Heart Attack		Stroke	
Diabetes		Mental Illness	
High Blood Pressure		Asthma/ Eczema	
Cancer		Epilepsy or Fits	

If so please give details below:

How much exercise do you take?

Is there anything special or unusual about you diet?

Please state what immunisations you have had e.g. tetanus, diphtheria, whooping cough, polio, MMR, rubella, etc.

Date	Immunisation

Women

Have you had a cervical smear? (If yes please give details) YES NO

Have you had a mammogram or other breast cancer screening? (If yes please give details) YES NO