The James Cochrane Practice

NHS

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?

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.

Please tick if you would be happy for us to send you text messages:	YES ☐	NO ☐
Please tick if you would be happy for us to leave a message on your answer machine:	YES ☐	NO ☐
Please tick if you would be happy for us to email you:	YES ☐	NO ☐

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 ☐

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:

The James Cochrane Practice*	Asda Pharmacy	Boots Pharmacy
Lloyds Pharmacy	Superdrug Pharmacy	Rowlands
Well Chemist –Burton Road – Highgate – Maude Street		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.

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 ☐

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

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 ☐