# Holyhead Primary Healthcare Centre

1 St. James Rd, Handsworth, Birmingham B21 0HL. Ph.NO:0121 5548516

NHS
Sandwell and West Birmingham
Clinical Commissioning Group

## New Patient Registration Form

Please complete in **BLOCK CAPITALS** and tick the boxes as appropriate.

**Patient details:**

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Title | Mr | | Mrs | | Miss | | Ms | | Date of birth | **/**/**** |
| Surname | | | | | | | | | First names | |
| Previous Surname | | | | | | | | | Occupation | |
| Home Address: | | | | | | | | | | |
| Postcode: | | | | | | | | | | |
| Tel No: | | | Mobile No: | | | | Work: | | | |
| | | | | | | | | | | |
| Name and address of previous GP: | | | | | | | | | | |
| | | | | | | | | | | |

**Next of kin:**

| | |
|---|---|
| Name: | Relationship: |
| Address: | |
| Contact number: | |

**Children:**

| Name of Child : | Date of birth : | Current School : |
|---|---|---|
| | | |

| | |
|---|---|
| Are you a carer for any other children? Yes/ No | Do you have parental responsibility? Yes / No |
| Any previous involvement with Children's Social Care? Yes / No | |

**Ethnicity:**

| | | |
|---|---|---|
| White | | British |
| | | Irish |
| | | Other (Please Specify) |

| | | |
|---|---|---|
| Black or Black British | | Caribbean |
| | | African |
| | | Other (please specify) |

| | | |
|---|---|---|
| Asian or Asian British | | Indian |
| | | Pakistani |
| | | Bangladeshi |
| | | Chinese |
| | | Other (Please Specify) |

| | | |
|---|---|---|
| Mixed | | White & Black Caribbean |
| | | White & black African |
| | | White & Asian |
| | | Other (please specify) |

| | | |
|---|---|---|
| Eastern European | | Polish |
| | | Romanian |
| | | Czech Republic |
| | | Other (please specify) |

| | |
|---|---|
| What is your first language? | |
| Do you require an interpreter? | Yes / No |

**P.T.O**

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**Proof of identity:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Birth certificate | | Driving licence | | Passport | | Utility bill |
| | Solicitor's letter | | Offer of tenancy | | Other: | | |

**Disabilities:**

Are you registered disabled? Y/N

If yes, please give details:

**Medication:**

Please list any medication and the dosages:

Are you allergic to any medicines? If so which? Y/N

**Medical information:**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Epilepsy | | | Blindness / Glaucoma | | |
| High blood pressure | | | Diabetes | | |
| Heart Attack / Stroke | | | Asthma | | |
| Cancer | | | Depression /mental illness | | |
| Eczema / Hay fever | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Have you had a flu vaccination? | | | Have you had a pneumococcal vaccination? | | |

| | | | |
|---|---|---|---|
| Have you had a cervical smear? | | | If yes, when and result if known: |

| | | | | | |
|---|---|---|---|---|---|
| Do you smoke? | | | Have you ever smoked? | | |
| Would you like advice on giving up smoking? | | | | | |

| | |
|---|---|
| How much alcohol do you drink in a week? | Units |
| Would you like advice or support to reduce your alcohol intake? Yes / No | |
| 1 unit = ½ pint beer 1 small glass of wine 1 single spirit 1 small glass of sherry or 1 single aperitif | |

| | | |
|---|---|---|
| Have you ever experienced domestic abuse? | Yes | No |
| Do you require any support? | | |

| | | |
|---|---|---|
| Would you be interested in joining our Patient participation Group? | | |

Name (Print): Date:

Signature: