PLEASE RETURN THIS FORM TO RECEPTION AFTER COMPLETION

CROSS DEEP SURGERY

NEW PATIENT INFORMATION - REGISTRATION FORM

Aged 6-15 Years

THIS FORM MUST BE COMPLETING IN FULL
FAILURE TO COMPLETE EVERY SECTION COULD RESULT IN A DELAY TO YOUR REGISTRATION

(A) Patients FULL Name:_____

Date of Birth:_____ NHS No (If Known): _ _ _ _ _ _ _ _ _ _

Address:_____

_____

Telephone Home:_____ Work:_____ Mobile:_____

Email Address: _____

(EMAIL ADDRESSED MUST BE PERSONAL – DO NOT GIVE SHARED EMAIL ADDRESSES)

Next of Kin:_____ Relationship: _____

Address Next of Kin:_____

Telephone Next of Kin:_____

Consent to Sharing Your Data

Attached to this Registration Form is a Opt Out/Consent form.
Please read this carefully to ensure you can make informed choices about whether you are happy for your data to be shared.

(B) SMOKING

Please circle the most appropriate option

Have you **EVER** Smoked? YES / NO *If NO moved to (C)*

Are you currently a Smoker? YES / NO *Answer the relevant questions below*

If Yes: Years Smoking: _____ Cigarettes/Cigars per day: _____Week:_____

If No: Date Started: _____ Stopped Smoking: _____

(D) ARE YOU A CARER? Yes / No (Delete as appropriate)

If Yes, Name of person for whom you care: _____

Date of Birth & Address of whom you care: _____

(E) DO YOU HAVE A CARER? Yes / No (Delete as appropriate)

If Yes, Name of person who cares for you: _____

Date of Birth & Address carer: _____

(F) ETHNIC INFORMATION

This information is important as certain diseases are more prevalent among people from particular areas of the world. Please tick most appropriate option:

Ethnic Category		*Tick here:*	*Additional Comments:*
WHITE	British		
	Any other White (please state)		
BLACK/BLACK BRITISH	Caribbean		
	African		
	Any other Black (please state)		
ASIAN / ASIAN BRITISH	Indian		
	Pakistani		
	Bangladeshi		
	Any other Asian (please state)		
MIXED ORIGIN	White & Black Caribbean		
	White & Black African		
	White & Asian		
CHINESE	Chinese		
ANY OTHER GROUP	Please State:		
PATIENT REFUSAL			

(G) Main Language Spoken: _____

(H) Please list:

(i) Any important medical problems you have had in the past:_____

_____

(ii) Any Medication that your are currently taking:_____

_____

(iii) Any family History of diabetes, heart disease or cancer:_____

_____

(iiii) Any Allergies you have:_____

_____