



The Robert Darbishire Practice – Patient Registration Form

Please use BLOCK CAPITALS and answer all questions. The information provided will form part of your medical record. *If you are returning from the **Armed Forces**, please let us know.*

OFFICE USE ONLY				
Out: Init/Date	In: Init/Date	Allocated GP/informed	Pt no.	NPHC Declined

Personal Details

- Mr Mrs Miss Ms Other: _____
- Surname: _____
- First names: _____
- Previous surname(s): _____
- Male Female
- Date of birth: ____ / ____ / ____
(day) (month) (year)
- NHS number: _____
(if known)
- Town and _____ : _____
country of birth
- If you are from abroad, the date you came to UK: _____

- Current Manchester address: _____
_____ Postcode: _____
 - How long will you be at this address?
 Less than 3 months More than 3 months
 - Are you in a stable housing situation?
 Yes No
- Examples of Yes: renting in your own name, living with parents/family, shared student house/hall, own home.*
Examples of No: staying temporarily with friends/family, emergency/temporary housing, homeless.
- Home telephone: _____
 - Work telephone: _____
 - Mobile* telephone: _____
 - Email*: _____

*We may send you messages by text or email, including appointment reminders. To opt out speak to a receptionist.

If You Are From Abroad

17. Why did you come to the UK? (Tick all that apply)

- Asylum seeker / refugee To escape war / persecution / etc (but did not apply for asylum)
 For work To study To live with / visit family Holiday Other

This question is to help us provide appropriate care. Your answer is confidential.

Previous GP Details

18. Have you ever been registered with a GP in the UK? Yes No

- Name and address of last GP/surgery: _____
- Your address while registered with that GP: _____
_____ Postcode: _____

Signature

- 21a. Signature of patient:
 21b. Signature on behalf of patient: _____ 22. Date: _____

Your Next of Kin / Emergency Contact

- Next of kin's name: _____
- Relationship to you: _____
- Next of kin's address: _____

- Telephone numbers: _____

Communication Needs

27. Do you have any special communication needs? Yes No

If yes, what are they? E.g. do you use a hearing aid, need an advocate, prefer contact by telephone or need information in large font?

- Support (eg: use hearing aid): _____ Professional: (eg: BSL Interpreter) _____
Contact method (eg: telephone): _____ Format (eg: Easy Read): _____

We may share your communication needs with other health and care services, e.g. if you are referred.

Please turn over

About You

28. Please choose one of the five sections and then tick your ethnic group:

(Please tick one box only)

These ethnic group descriptions are a national standard taken from the 2011 census.

	White	Mixed / Multiple Ethnicity
	<input type="checkbox"/> White British <input type="checkbox"/> White Irish <input type="checkbox"/> Gypsy or Irish Traveller <input type="checkbox"/> Other White– please write in:	<input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian <input type="checkbox"/> Other Mixed– please write in:
Asian / Asian British	Black / Black British	Other
<input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Chinese <input type="checkbox"/> Other Asian– please write in:	<input type="checkbox"/> Black Caribbean <input type="checkbox"/> Black African <input type="checkbox"/> Somali <input type="checkbox"/> Other Black– please write in:	<input type="checkbox"/> Arab <input type="checkbox"/> Any other – please write in:

29. Which best describes your sexual orientation?: Heterosexual/Straight Gay/Lesbian Bisexual

30. Are you a main carer (unpaid) for someone who has poor health or disability? Yes No

Health and Lifestyle

31. Do you take regular medication? Yes No

32. If you tell us your preferred pharmacy we can deliver most prescriptions there electronically.

Name and address of chosen pharmacy: _____

33. Do you have any long-term illness, health problem or disability? Yes No

34. Do you have a carer (paid or unpaid) due to poor health or disability? Yes No

35. Do you smoke? I've never smoked I smoke => cigarettes per **day**: _____*
 I used to smoke => Date I quit: _____

* **Smoking is bad for your health.** For help to quit please call **0300 123 1044** or visit www.nhs.uk/smokefree.

36. How often do you have a drink containing alcohol?

₀ Never ₁ Monthly or less ₂ 2-4 times per month ₃ 2-3 times per week ₄ 4+ times per week

Alcohol units: Pint of beer/lager/cider = 2, Single spirits (25ml) = 1, Glass of wine (175ml) = 2, Alcopop = 1.5

37. How many units of alcohol do you drink on a typical day when you are drinking?

₀ 1-2 ₁ 3-4 ₂ 5-6 ₃ 7-8 ₄ 10+

38. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? ₀ Never ₁ Less than monthly ₂ Monthly ₃ Weekly ₄ Daily or almost daily

Language

39. My main spoken language is: _____ (one only)

40. Do you have any problems reading English?

- I have no problems
 I have some problems
 I have a lot of problems

41. Do you have any problems speaking English?

- I have no problems
 I have some problems
 I have a lot of problems

42. If English is not your main spoken language, do you need an interpreter (someone to help with language) when you visit the doctor? Yes No

Current University students only

43. Are you currently a full-time or part-time University student? Yes No

If "No", please ignore the rest of this section.

44. Which University? _____

45. Course end date: _____

46. Are you an overseas student? Yes No

Thank you for completing this form. The information will help us plan our service better. For more details about how we use your information, please see our website or practice leaflet.