PLEASE RETURN THIS FORM TO RECEPTION AFTER COMPLETION

# CROSS DEEP SURGERY

# NEW PATIENT INFORMATION - REGISTRATION FORM

## Aged 16+

**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:_____

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**(Ai)** If you would like to register for online services please complete the online access form attached. (16+ Only)

**(Aii)** ☐ I would like to Opt out of having a Summary Care Record (#9Ndo)

**(Aiii)** ☐ I would like to Opt out of data extraction (#9Nu0 & #9Nu4)

Note: If you are Unsure about Sections Aii & AiII then we advise patients to read the information available o on our website and in our waiting area in order to make an informed decision – You can opt out and opt back in at any time.

Signature_____ Date_____

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**(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: _____

| **(C) ALCOHOL**<br>**Please circle the most appropriate option** | **Scoring system** | | | | | **Your score** |
|---|---|---|---|---|---|---|
| | **0** | **1** | **2** | **3** | **4** | |
| How often do you have a drink containing alcohol? | Never | Monthly or less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week | |
| How many units of alcohol do you drink on a typical day when you are drinking? | 1 -2 | 3 - 4 | 5 - 6 | 7 - 9 | 10+ | |
| 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? | Never | Less than monthly | Monthly | Weekly | Daily/ almost daily | |
| | | | | | Total Score | |

**(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: _____

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**(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:_____

_____