**Billet Lane Medical Practice**

**Dr Jeelani and Dr Jegede**

**58B Billet Lane, Hornchurch, RM11 1XA**

**Tel 01708 442377**

**New Patient Registration Form**

**Please complete this form in BLOCK CAPITALS and return to the Receptionist at Billet Lane medical Centre**

**Patients for new registration over 16 years**

|  |  |
| --- | --- |
| **Mr Mrs Ms Miss other ...............** | **Male \ Female** |
| **Surname** | **Address** |
| **First name** |  |
| **Middle name** |  |
| **Date of birth** |  |
|  |  |
| **Home Tel** | **Postcode** |
| **Email address** | **Repeat email address** |
| **Mobile** | **Work telephone no.** |

**It is the PATINETS responsibility to keep the GP up to date with their latest contact details. Please always check we have the correct contact details for you. In an emergency this could save valuable time. Also you could be deleted from the patient List if we cannot contact you or we have a letter returned to the surgery.**

|  |  |
| --- | --- |
| **NHS number ... ... ...\ ... ... ..\ ... ... ... ...**This is a 10 digit number 3\3\4 you can find on your medical card or from your previous GP. This is NOT your NI number. | **Previous GP (doctor) Name** **Address** **Post code** |
| **Marital Status – Single\Married\Separated\Co-habiting\Divorced\Widowed\Engaged\ other please state ...** |
| **Country of birth** | **Occupation** |
| **Date of entry in to UK**  |  |

**Please let us know if you have other patients you would like to be linked to (family or friends, they maybe already registered at the Practice or registering as new patients. If they are registering please state NEW by their name.**

|  |  |  |
| --- | --- | --- |
| **Name**  | **Address (or same)** | **Relationship to you** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**We would like to know some lifestyle information for our records**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Do you drink ALCOHOL?** | **Currently drink** |  | **Lifelong teetotaller** |  | **EX -Drinker** |  |
|  | **Number of units a week** |  | **Date stopped drinking** |
|  |  |  | **Are you pregnant Yes\no** |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Exercise Grading** | **Inactive** |  | **Moderate** |  | **Vigorous** |  | **Gentle** |  |
| **Your Diet** | **Good** |  | **Moderate** |  | **Poor** |  | **Vegetarian\vegan** |  |
| **Smoking** | **Smoker** |  | **Never Smoked** |  | **Ex-smoker** |  | **Date stopped smoking** |  |
| **If you smoke how many a day do you smoke** |  | **cigarettes** |  | **cigars** |  | **tobacco** |  |

**Please tell us what your**

|  |  |
| --- | --- |
| **Height** | **Weight** |

**CARERS CONSENT**

|  |  |  |
| --- | --- | --- |
| **You will need to let us know if you are a registered carer or if you are cared for by someone. Are you a Carer?** | **Yes\No** | Details: |
| **Does someone Care for you?** | **Yes\no** | Details: |

**Health information**

**Do you have any of the following conditions?**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Asthma** | **Diabetics** | **Dementia** | **Learning****Disabilities** | **Heart****Problems** | **Mental****Health****problems** | **High blood****pressure** |  | **Any other****Serious****conditions** |
| Give brief Details |  |  |  |  |  |  |  |  |

**Do you take regular Medication?**

If you take regular medication you will need to make an appointment to see the Nurse for either a Health Check. If you need a Medication Review please make a routine appointment to see the Doctor. This should be **at least a week after** you give your paperwork to be processed. We need to have your previous medical records before this appointment. This is so the clinician can check we have your up to date medical history on our system.

|  |  |
| --- | --- |
| **Please let us know what Medication you take**  | **Quantities and dosage** |

**WOMEN ONLY**

**Are you Pregnant Yes/No If you are pregnant , have you started your anta-natal care? Yes/No**

**If NO please make a routine appointment with the Doctor to start your Anta-natal plan.**

**Family Planning: Which Pill do you take?...................................................**

**If you need to review your family Planning please make an appointment.**

**When was your last Smear? …………………………**

**Please indicate your Ethnic origin.**

British white Irish Scottish Welsh White Other ...........................

Black British Black Caribbean Black African Black West Indian Black Other .............

Indian Pakistani Bangladeshi Chinese Mixed Race ..................................

I do not wish to give my ethnicity

**What is your first spoken Language?......................................**

**Can you speak English? ..............................**

**Next of kin name and contact details………………………………………………………………………….**

**Thank you for completing your registration forms, working together we hope to provide the best care for your health we can. It is your responsibility to check we have your most up to date information both medical and personal.**

**Please sign to confirm the information you have given is correct to the best of your knowledge and you understand your responsibility as a patient ..............................**

**Date ...........................**

**For further information about Billet Lane Medical Practice and services we provide you can go to our Website: WWW.Billet Lane Medical Practice or from our Practice Booklet.**

**We encourage our Patients to use our ON-LINE Services. Please ask for a registration Form**