Please complete the following information and hand it back to Reception. Thank you.

**YOUR DETAILS**

|  |  |
| --- | --- |
| Surname: | Title: Mr/Mrs/Miss/Ms/Dr/Other |
| Forenames: | |
| Date of Birth: | Previous Surname(s): |
| Address: | |
| Post Code: | Home Phone: |
| Email: | |
| Mobile Phone: | Work Phone: |
| Do you consent to receive:  SMS notifications for clinical services. Yes No  E-mail notifications for clinical services Yes No | |
| What is your first language? | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **NEXT OF KIN**   |  |  | | --- | --- | | Surname: | Title: Mr/Mrs/Miss/Ms/Dr/Other | | Forenames: | | | Date of Birth: | Previous Surname(s): | | Address: (if different from above) | | | Post Code: | Home Phone: | | Email: | | | Mobile Phone: | Work Phone: | | Relationship to You? | | |

Continues overleaf

## ETHNICITY DATA

We have been asked to request ethnicity data for patients registering with the practice. This section is entirely optional. If you would prefer not to state your ethnic origin please skip this section.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **White** | | **Black** | | **Asian** | | **Mixed** | |
| White British |  | Caribbean |  | Indian |  | White & Black Caribbean |  |
| White Irish |  | African |  | Pakistani |  | White & Black African |  |
| Other White |  | Other Black |  | Bangladeshi |  | White & Black Asian |  |
|  |  |  |  | Chinese |  | Any other Mixed background |  |
|  |  |  |  | Other Asian |  |  |  |
| Other (Please specify) | | |  | | | | |

**SMOKING**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **I am a non-smoker\*** | | **I do smoke tobacco** | | | |
| Never been a smoker |  | Cigarette Smoker |  | No per day |  |
| Ex-Cigarette Smoker |  | Roll-Up Cigarette Smoker |  | No / Oz per week |  |
| Ex-Pipe Smoker |  | Cigar Smoker |  | No per day |  |
| Ex-Cigar Smoker |  | Pipe Smoker |  | Oz per week |  |

*If your only smoking experience is teenage experimentation we think it is reasonable to class yourself as never having been a smoker*

**Are you are a Smoker and want to give up? Did you know that stopping smoking support and nicotine replacement treatment makes giving up much more successful? Ask at reception for information about stopping smoking support.**

**CARER**

|  |  |
| --- | --- |
| Are you a Carer? | Unpaid Employed |
| If Unpaid, Whom do you care for? | |
| Are they registered at North Curry Health Centre? Yes No | |

**BLOOD PRESSURE**

Please can you take your Blood Pressure using the machine here at the surgery it is located in the waiting room.

|  |  |  |
| --- | --- | --- |
| **Date taken** | **Pulse** | **Blood pressure** |
|  |  |  |

Signed: …………………..……….……………………. Date: ……………………….…………..

|  |  |
| --- | --- |
| (For Office Use Only) EMIS NO: |  |