**APPLICATION FOR REGISTRATION AT THE SURGERY,**

**Horndon-on-the-hill**

**NAME:** ……………………………………………………… **DATE OF BIRTH:** …………………………………………………

**MALE FEMALE**

**MARITAL STATUS** (Tick as appropriate)

SingleMarriedCo-habitingSeparatedDivorcedWidowed

**Are you a Registered Carer? Yes No**

**ETHNIC ORIGIN** …………….………………… **FIRST LANGUAGE** …………………………………………

**PRESENT ADDRESS PREVIOUS ADDRESS**

………………………………………………………………………… ……….………….……………………………………………………….

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**HOME TELEPHONE NUMBER WORK TELEPHONE NUMBER MOBILE TELEPHONE NUMBER**

……………………………………………………… ……………………………………………………… …………………………………………………

**Text Messaging Service: Do you consent: Y/N**

**(**We send appointment reminders and other important messages automatically, Please delete as appropriate)

**E-MAIL:………………………………………………… OCCUPATION:** ……………………………………………………………….…………………

**Are you willing to consent to shared care with another party (e.g. Hospital)**

**YES/NO** (delete as appropriate)

**NAME AND ADDRESS OF PREVIOUS GP:** ………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………………………………………………………………

**REASON FOR CHANGE:** ………………………………………………………….…………………………………………

**HOW MANY TIMES HAVE YOU VISITED UP GP IN THE LAST 12 MONTHS?** ………………………………………………..

**DO YOU HAVE RELATIVES LIVING IN THE AREA? YES/NO** (delete as appropriate)

**DO YOU HAVE ANY RELATIVES REGISTERED WITH THIS PRACTICE?**

**YES/NO** (delete as appropriate)

**MEDICAL HISTORY** (list serious or chronic illnesses, operations etc)

……………………………………………………………………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………………………………………………………………

**ANY MEDICAL CONDITIONS:** Asthma High Blood Pressure Diabetes

Stroke Heart Problems Arthritis

**HABITS: Smoking** How many per day .……………………………………..

**Alcohol** How many units per week …….………………………………..

**Other Drugs**

(please state) ……………………………………………………………………………………………..

**FAMILY MEDICAL HISTORY**

**Father** …………………………………………………….…………… **Mother** …………………………………………………………………

………………………………………………………………….. …………………………………………………………………

**ALL MEDICINES YOU TAKE ON A REGULAR BASIS**

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**FEMALES ONLY** Date of Last Cervical Smear ………………………………………………………………………………....

**CHILDREN ONLY (under age of 16)**

Immunisation and dates ……………………………………………………………………………………………………………………………………………

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**Signature** …………………………………………………………………… **Date** …………………………………………………………………