

Saxon Cross Surgery -Patient Registration Form

PLEASE COMPLETE ALL SECTIONS

First Name(s) Surname

Title: Mrs Ms Mr Other: (please indicate) Date of Birth

Address:

Postcode:

Landline Telephone No: Mobile telephone No:

Work Telephone No:

Would you like to receive confirmation of appointments by SMS text (mobiles only) Yes/No

Are you happy for us to leave messages on any answerphone asking you to contact us (no medical information will be left):

Landline Yes/No

Mobile Yes/No

Work Yes/No

E Mail Address:

Looking to the future, would you like to receive details of activity in the surgery by email (eg flu clinic dates) Yes/No

Your Occupation:

Marital status: (please circle) Common law Partnership/Divorced/Married/Separated/Single/Widowed

Next of Kin: Relationship to you:

Address if different:

If the patient registering is under 18 years of age, please give name and contact number of parents/carer

Mother: Contact telephone number:

Father: Contact telephone number:

Carer: Contact telephone number:

Name & Date of birth of other Children in the household (continue on separate sheet if necessary)

Name: Date of Birth:

Name: Date of Birth:

Name: Date of Birth:

Name: Date of Birth:

Are you a Carer? Yes/No

Is the person you care for a: Relative/Neighbour/Friend/Other (circle as appropriate)

Please give details of who you care for:

Are you in receipt of a Carers Allowance?:

Yes/No

Would you like information about help for carers?

Yes/No

Do you have a Carer? Yes/No

If yes please give details:

Name:

Contact Telephone No:

Relationship to you: Relative/Neighbour/Friend/Other (circle as appropriate)

Are you happy for us to speak to your carer about your medical care?

Yes/No

Ethnicity: (please circle as appropriate)

White:

British/Irish/Other

Black or Black British :

Caribbean/African/Other

Mixed:

White/Black Caribbean

White/Black African

Other

Asian or Asian British:

Indian/Pakistani/Bangladeshi/Other

Chinese:

Other – Please specify

Are you an English speaker :

Yes/No

First language spoken:

Signature:

Date:

Office Use only: Identification documents submitted (one from each list required- tick as appropriate)

Birth Certificate

Local Authority rent card/Council tax bill

Marriage Certificate

Paid Utility Bill

Medical Card

Bank/Building Society Statements

Photographic Driving Licence

Payslip

Passport

Letter from Benefits agency/Benefit

Book/Signing on card

Papers from Home Office

P45/P60

Date of Registration Medical

ID Seen By (staff initial):