**Broadway Surgery New Patient Registration – Adolescent Between 13 – 16y**

**Please complete all sections in FULL using BLOCK capital letters.**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Your Details** | | | | | | | | | | |
| Title | | Mr  Mrs  Miss  Ms  Other | | | | | | | | |
| Surname | |  | | | | | | | | |
| First Name(s) | |  | | | | | | | | |
| Previous Surname  (if applicable) | |  | | | | | | | | |
| Date of Birth (dd/mm/yyy) | |  | NHS Number | | | |  | | | |
| Gender | | Male  Female | | | | | | | | |
| Town & Country of Birth | |  | | | | Date you came to live in the UK if born abroad: | | | |  |
| Address | |  | | | | | | | | |
| Previous Address | |  | | | | | | | | |
| Telephone Number | |  | Mobile Number | | | | |  | | |
| Email address | |  | | | | | | | | |
| Contact/Communication Preference | | Letter  Email  SMS  No Preference | | | | | | | | |
| **Personal Medical History** | | | | | | | | | | |
| Name of your previous GP surgery | |  | | | | | | | | |
| Address of previous GP surgery | |  | | | | | | | | |
| Has you ever suffered from any important medical illness, operation or admission to hospital? | | If so, please state: | | | | | | | | |
| Have any close relatives (mum, dad, sister, brother ONLY) ever suffered from: | | High blood pressure Diabetes Heart Attack Stroke Cancer  Asthma Glaucoma Other If other, please state: | | | | | | | | |
| Allergies | |  | | | | | | | | |
| List of Current Medication | |  | | | | | | | | |
| **Lifestyle** | | | | | | | | | | |
| Smoking Status | | Smoker Never Smoked Ex-Smoker | | | | | | | | |
| If you’re a smoker do you smoke: | | Cigarettes Rollups Vape | | | | | | | | |
| How many cigarettes/cigars do you smoke daily? | | <1/day 1-9/day 10-19/day 20-39/day 40+/day | | | | | | | | |
| Would you like help to quit? | | Yes  No | | | | | | | | |
| **About You** | | | | | | | | | | |
| Ethnicity | | White British Irish Other White Background White & Black African White & Black Caribbean Other Mixed Background Indian or British Indian Pakistani or British Pakistani Bangladeshi or British Bangladeshi Other Asian Background Black British African Caribbean Chinese Other  If other, please state: | | | | | | | | |
| Main Spoken Language | |  | | | Do you speak English? | | | | Yes  No | |
| Height (m) | |  | | | Weight (kg) | | | |  | |
| Next of Kin Name | |  | | | | | | | | |
| Relationship to Next of Kin | |  | | | | | | | | |
| Next of Kin Tel. Contact Number | |  | | Are they registered here? | | | | Yes  No | | |
| **Consent and Data Sharing** | | | | | | | | | | |
| To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments).  **Do you give us your consent to share certain medical information with other hospitals?**  Yes  No  Where you have provided information on how to contact you, can you confirm you are happy for The Broadway Surgery to contact you by the following:  By email Yes  No  This will be to send you letters, newsletter and the like.  By text Yes  No  This will be to send you reminders of appointments via text | | | | | | | | | | |
| I can confirm that the information I have provided is true to the best of my knowledge. | | | | | | | | | | |
| Signature |  | | | Date | | | |  | | |
| Signature of Patient  Signature on behalf of patient | | | | | | | | | | |