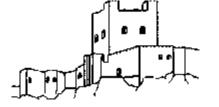
Date of Registration:		
EMIS Number:	Your Initials:	



The Castle Practice

UNDER 18

New Patient Registration Questionnaire Please complete all sections of this form in their entirety

The completion of this form is essential for our records.

(October 2023 Version)

CECT				001	A 1	DET	A 11	0-
SECT	IUN	A -	PER	SUN	AL	ᄓᆫᆝ	AIL	. O.:

PLACE OF BIRTH:						
		DOB:				
		H&C No:				
ADDRESS		PREVIOUS ADDRESS				
HAVE YO	OU LIVED OUTSIDE OF THI	E UK FOR		YES/NO		
	RIOD OF TIME IN THE LAST		? (Recept		Form HS22X needed)	
HOME TELEPHONE NO:		(Reception - if Yes - Form HS22X needed) MOBILE NO:				
WORK NO:		EMAIL ADDRESS:				
PREVIOUS GP DETAILS: Name and Address		Have you registered with the Castle Practice Before? Yes/No Have you ever been registered within the UK? Yes/No First Language:				
School/College Attending: Name and Address		Please list details of any person/persons living at the registered home address, who IS NOT registered with the Castle Practice				
			Name	DOB/Age	Relationship to Child	
	ORIGIN - Please circle acco					
White	Asian or Asian British	Mixed		Black or Black British		
British	Indian		Black Caribbean	Caribbean		
Irish	Pakistani		Black African	African		
Other	Bangladeshi	White and Asian		Other		
.	Other	Other				
	or other Ethinc group	Not State	d or Other			
Chinese Other						
Other						
SECTION	N B - HEALTH STATUS INF	ORMATION				
SMOKIN	G STATUS - Have you ever	smoked?		Yes/No	1	
	If Yes, are you		smoker?	Yes/No		
If Yes, how many do you smoke per day?						
			nal handout given k	y receptionis	st.	

The Castle Practice

Date of Registration:	
FMIS Number:	Your Initials:

New Patient Registration Questionnaire

Page 2

UNDER 18

SECTION C - MEDICAL HISTORY

Do you suffer from -	Asthma	Yes/No	
•	Heart Disease	Yes/No	
	Diabetes	Yes/No	
	Stroke	Yes/No	
	Epilepsy	Yes/No	
	COPD/Bronchitis	Yes/No	
	Thyroid Problems	Yes/No	
	High Blood Pressure	Yes/No	
	Any other significant med		Yes/No
If you answered Yes to any of the abor from your previous GP surgery			
Castle Practice participates in the Dand Opiodes Reduction programme Patients should be aware that prese with the Department of Health Guid	e. criptions and medication elines.	s will be reviewed	
FLEASE HOR HERE TO COM IRW	IOO HAVE KEAD IIIIS N	OTICE	_
Non-Physical Abuse; The use of ina harassment. This inclu Physical Abuse; The intentional	ertake their duties witho appropriate words or beh des receipt of abusive to	ut fear of abuse o aviour causing di elephone calls fro nst the person or	r violence. stress and/or constituting m any source another without lawful
VACCINATION HISTORY			
Please provide a copy of your childs v GP surgery or a copy of your childs Re accept your childs registration.	-	-	
For completion by Reception:- Type of Registration	HS22X/HS200/Medical C	Card	
Photographic ID copied	Yes D	ate:	(initial)
Visa/Permit copied (if necessary)		ate: ate:	(initial) (initial)
GP Alerts Database checked		ate: ate:	(initial) (initial)
Ethnic Origin coded		ate: ate:	(initial)
Smoking Status/Alcohol Status Coded	Tes D	ai c	(initial)
SHIUNING STATUS/AICUNUI STATUS CODED	Von D	oto:	(initial)
<u> </u>		ate:	(initial)
Smoking Information Leaflet Given (if Vaccination History Copied	smoker) Yes D	ate: ate: ate:	_ , ,