**Bodmin Road Health Centre**

**New Patient Registration Form – Adult**

Name:………………………………………………………………………………………………Date of Birth:…./…./………

Home Address:………………………………………………………………………………………………………………………..

Post Code:……………………

Home Phone:…………………………………………………………..Mobile Phone:……………………………………..

Email:………………………………………………………………………………………………………

Next of Kin…………………………………………………………………………Contact details…………………………….

Preferred Language(s)……………………………………………………………………………………………………………..

**Ethnic Group:**

Please choose / circle one of the following:

1. White: British, Irish, Other (please specify……………)
2. Mixed:
* White and Black Caribbean
* White and black African
* White and Asian
* Any other mixed background (please specify………..)
1. Asian or Asian British
* Chinese
* Indian
* Pakistani
* Bangladeshi
* Other Asian Background (please specify……………..)

D)Black or Black British

* Caribbean
* African
* Other Black Background (please specify…………….)

E) Other Groups

* Arab
* Any other Ethinc Group (please specify…………….)

**Gender**

Which of the following best describe your gender?:

Woman (including trans woman)

Man (including trans man)

Non-binary

In another way

Is this the same as your gender at birth? Yes / No

**Sexual Orientation**

Please tick the sexual orientation that best represents you:

Heterosexual / Straight

Gay / Lesbian

Bisexual

In another way ( please specify)…………………………………..

**Disability Status**

Do you have a disability? (if so please specify…………………….)

Yes / No

**Carer Status**

Are you a carer?: Yes / No

Who do you are for?: …………………………………………………………………………………………………………………………………………………………………………

Do you have a carer?: Yes ? No

If so what is their name and contact number?:

…………………………………………………………………………

**Military Veteran**

If you are a military veteran, please state which service and when you were discharged: ……………………………………………………………………………….

**Medication:**

Please state if you are on routine repeat medications and provide a list of all medications you take. Yes/No

Please ensure you have at least 4 weeks of medication from your previous GP

Do you have any allergies, if so state them here:

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

**Your Health**

Please specify any long term health issues eg asthma, diabetes, epilepsy, heart disease or chronic obstructive pulmonary disease:

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

Do you have any Mental Health problems : eg depression, anxiety, OCD, bipolar? (please specify below):

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

Have you had a HIV test?: Yes / No

You can request a routine HIV test at the practice.

Date of last smear if known……………………………………………..

**Family History**

Please list any illnesses that run in your family, including which family member has / had it:

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

**Alcohol Status**

How many units of alcohol do you drink weekly?:…………………

**Smoking**

Do you smoke currently? Yes / No

How many a day if so?…………………………..

Date you gave up if ex smoker?…………………………

**Communication Needs:**

Do you have any information or communication needs? Yes / No

If so please state (eg braille, large print, sign language) …………………………………………………………………………..

Do you need an interpreter? Yes / No

If so, which language?...........................................................

Do you have a learning difficulty? Yes / No

Do you have any impairment of mental capacity? Yes / No

Do you have a Lasting Power of Attorney set up? Yes / No

If so please give details of who your attorney is (with contact information and their relationship to you)?…………………………………………………………………………………………………………………………………………………………………

**Summary Care Record**

Do you consent to sharing of your record with other NHS services when you are accessing care (eg NHS Out of Hours, Emergency Department etc) Yes / No

**GDPR Data Protection ( General Data Protection Regulation)**

GDPR gives you rights to protect your data that we hold. We need consent before we can use data for any activities not directly related to your health.

This means we can contact you regarding health-related issues (eg appointments, screening requirements, flu vaccinations etc) but consent would be needed to contact other non-health related activities ( eg satisfaction surveys, clinical research projects).

Please indicate your preference:

Yes, you can contact me regarding non-health related issues that may benefit me / the practice

No, please do NOT contact me regarding non-health related issues that may benefit me / the practice