NEW PATIENT REGISTRATION FORM. PLEASE USE BLOCK CAPITALS

Clarence Medical Centre, Windsor, Berkshire. Branch surgery at Royal Holloway, University of London

Department		Student Number				
Year Course	Starts: Ends:	Male		Female		Other

Surname			
First Name(s)			
Date of Birth	(DD/MM/YYYY)	Nationality	
Mobile Number		RH Email	

NHS number *(If known)*										

Height:		Weight:	
Do you smoke?	Yes ❑ No ❑	How many per day?	
Do you drink alcohol?		How much per week?	

Do you suffer from any of the following conditions?

Asthma:	Yes ❑ No ❑	Epilepsy:	Yes ❑ No ❑
Diabetes:	Yes ❑ No ❑	Thyroid	Yes ❑ No ❑
Eating Disorders:	Yes ❑ No ❑	Depression / Anxiety:	Yes ❑ No ❑
Psychiatric Conditions:	Yes ❑ No ❑	Any Operations:	Yes ❑ No ❑

Are you currently receiving any medical treatment / medication? Yes ❑ No ❑	*Details:*
Are you allergic to any medication? Yes ❑ No ❑	*Details of which medication and what symptoms:*

Next of Kin Details

Name:		Address:	
Relationship:			
Telephone:		Postcode:	

I give consent for the NHS to contact me by university email	Yes ❑ No ❑	I give consent for relevant health details to be shared if required with Student Services & my Academic Department	Yes ❑ No ❑

OFFICIAL USE ONLY:

Date Received:			
Questionnaire & GMS checked by:			
Date Patient Registered:		Registered by:	

Family doctor services registration

GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ✔ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

Please help us trace your previous medical records by providing the following information

Your previous address in UK

Name of previous doctor while at that address

Address of previous doctor

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving

Date you first came to live in UK

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

☐ I live more than 1 mile in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

**Not all doctors are authorised to dispense medicines*

☐ **Signature of Patient** ☐ **Signature on behalf of patient** Date_______/_______/_______

Version 01/02

Please see overleaf re: Organ donation