**Moorland Medical Centre**

**Today’s Date:**

# New Patient Questionnaire

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Please complete a separate form for each family member to be registered.

|  |  |
| --- | --- |
| **Full Name:** | **Telephone Number:** |
| **Mr / Mrs / Miss / Ms / Other……..** | **Work Number** |
| **Address and Postcode** | **Mobile Number:** |
| **E-mail Address:** |
| **Next of Kin:** |
| **Next of Kin Contact Number:** |
| **Date of Birth:** | **Previous / Mother’s surname if different:** | **Town & Country of Birth** |
| **Marital Status:** |  | **Gender:** | **Male:** | **Female:** | **Other residents of your home:** |
| **Occupation:** |
| **Names & Ages of Children** |
| **For children aged 5-16 years please state school attending** |  |
|  |
| **Your Ethnic Origin:****(select one)** |  |  |  |
| **Asian or Asian British** |  **Indian** | **Pakistani** |  **Bangladeshi** | **Chinese** | **Any other Asian background** |
| **Black, African, Caribbean or Black Britsh** |  **African** | **Caribbean** | **Any other Black, African or Caribbean background** |  |
| **Mixed or multiple ethnic groups** |  **White or Black Caribbean** | **White and Black African** |  **White and Asian** | **Any other mixed or multiple ethnic background** |
| **White** | **English, Welsh, Scottish, Northern Irish or British** | **Irish** | **Gypsy or Irish traveller** | **Any other white background** |
|  |  |  |  |  |
| **Other Ethnic group** | **Arab** | **Any other ethnic group** |  |
|  |
| **Your main or 1st language Spoken / Understood:****(select one)** | **English** | **Hindi** | **Gujurati** | **Urdu** | **Bengali /Sytheti** |  |
| **Polish** | **Ukrainian** | **French** | **German** | **Spanish** | **Other:****(Please****Specify)** |

**Preferred Method of Communication**

From time to time, we, as a Practice need to contact our patients- whether it’s to remind you that certain health check-ups are due, or to notify you of results etc, there can be several reasons why we might need to get in touch.

In order to ensure that when we do need to reach you, we are using the method that is most suitable for you, please could you complete the table below. While we will always endeavour to reach you in the way that you have requested- on occasion where the matter may be urgent, we may have to try any/ all means of contacting you.

Please tick the option that you prefer, and confirm in the space beside it, what your current contact information is that you’d like us to use when contacting you.

|  |  |  |
| --- | --- | --- |
| Preferred Method of Contact | Tick | Current contact information |
| No Preference |  |  |
| Home Telephone No. |  |  |
| Work Telephone No. |  |  |
| Mobile Telephone No. (phone call) |  |  |
| Mobile Telephone No. (Text Message) |  |  |
| Letter to Home Address |  |  |
| Letter to Temporary Address |  |  |
| Email |  |  |

Patient signature: ……………………………………………………………………………………. Date: ………………………………

|  |
| --- |
| **Patient Participation Group****The Practice is committed to improving the services we provide to our patients.** **To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.** **By expressing your interest, you will be helping us to plan ways of involving patients that suit you.** **It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.****If you are interested in getting involved, please tick the box below and we will arrange for the Practice Patient Participation Group Application Form to be given to you at your initial consultation.**  |
| **Yes, I am interested in becoming involved in the Practice Patient Participation Group (Please tick the “Yes” Box)** | **Yes** |
|  |
| **Patient****Signature:** |  | **Signature on****behalf of Patient:** |  |