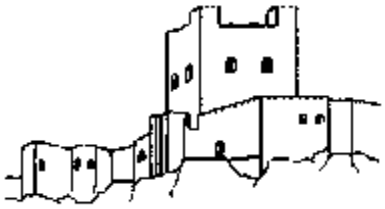
Date of Registration:	
EMIS Number:	Your Initials:



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.

SECTION A - PERSONAL DETAILS: **(October 2023 Version)**

PLACE OF BIRTH:

NAME:	**DOB:**
	H&C No:
ADDRESS	**PREVIOUS ADDRESS**
HAVE YOU LIVED OUTSIDE OF THE UK FOR ANY PERIOD OF TIME IN THE LAST 10 YEARS?	**YES/NO (Reception - if Yes - Form HS22X needed)**
HOME TELEPHONE NO:	**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

ETHNIC ORIGIN - Please circle accordingly

White	**Asian or Asian British**	**Mixed**	**Black or Black British**
British	Indian	White and Black Caribbean	Caribbean
Irish	Pakistani	White and Black African	African
Other	Bangladeshi	White and Asian	Other
	Other	Other	

Chinese or other Ethinc group	**Not Stated or Other**
Chinese	
Other	

SECTION B - HEALTH STATUS INFORMATION

SMOKING STATUS - Have you ever smoked?	**Yes/No**
If Yes, are you a current smoker?	**Yes/No**
If Yes, how many do you smoke per day?	
If Yes, please see additional handout given by receptionist.	

The Castle Practice

Date of Registration:

EMIS Number: Your Initials:

New Patient Registration Questionnaire

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 medical condition?		Yes/No

If you answered Yes to any of the above, please provide a list of your medication from your previous GP surgery

Castle Practice participates in the Department of Health led Benzodiazepines Reduction and Opiodes Reduction programme.
Patients should be aware that prescriptions and medications will be reviewed in line with the Department of Health Guidelines.

PLEASE TICK HERE TO CONFIRM YOU HAVE READ THIS NOTICE ☐

ZERO TOLERANCE - In line with the Department of Health, Social Services and Public Safety Circular HSS (Gen) (3) 2007 - "Zero Tolerance on Abuse of Staff, Protecting Healthcare and Emergency Staff from Violence", the Castle Practice is committed to the creation of a culture and environment where employees may undertake their duties without fear of abuse or violence.

Non-Physical Abuse; The use of inappropriate words or behaviour causing distress and/or constituting harassment. This includes receipt of abusive telephone calls from any source
Physical Abuse; The intentional application of force against the person or another without lawful justification resulting in physical injury or personal discomfort.

VACCINATION HISTORY

Please provide a copy of your childs vaccination history. This can either be a printout from your previous GP surgery or a copy of your childs Red Book information. Without this information we are unable to accept your childs registration.

For completion by Reception:-

Type of Registration *HS22X/HS200/Medical Card*

Photographic ID copied	*Yes*	*Date:*	_____ *(initial)*	_____
Visa/Permit copied (if necessary)	*Yes*	*Date:*	_____ *(initial)*	_____
GP Alerts Database checked	*Yes*	*Date:*	_____ *(initial)*	_____
Ethnic Origin coded	*Yes*	*Date:*	_____ *(initial)*	_____
Smoking Status/Alcohol Status Coded	*Yes*	*Date:*	_____ *(initial)*	_____
Smoking Information Leaflet Given (if smoker)	*Yes*	*Date:*	_____ *(initial)*	_____
Vaccination History Copied	*Yes*	*Date:*	_____ *(initial)*	_____