The Grove Medical Practice
Registration form

To be completed by all patients registering at the practice

PERSONAL DETAILS AND CONTACT INFORMATION

Name: ………………………………………………………………………………………………….

Sex: Male ☐ Female ☐ Date of Birth: ……………………………………..

Telephone number: ………………………………… Mobile number: …………………………………..

Preferred number (tick one): ☐ Landline ☐ Mobile

We encourage all patients to provide their <u>own</u> mobile number. Please confirm below if this mobile number belongs to you or to someone else:

This mobile belongs to me ☐
This mobile does not belong to me ☐
If someone else, who does this belong to? …………………………………………………………………

Are you happy to receive text messages from the practice? This will include confidential information such as appointment times, follow-up of test results and requests to contact us if we need to see you for any reason. You can let us know if you change your mind at any time.

I consent to receiving text messages ☐ I <u>do not</u> consent to receiving text messages ☐

Would you like to sign up for online services? This will enable you to book appointments, request repeat prescription and view some of your medical records.

☐ Yes ☐ No

NEXT OF KIN

Please provide details of your next of kin whom we may contact in an emergency:

Next of kin: ………………………………………………………………………………………..…………………

Relationship to you: ……………………. Telephone: ……………………… Mobile: ……………………...

CARER

Do you have a carer? ☐ Yes ☐ No

Name of carer: …………………………………………….. Telephone: ……………………………………

Are you happy for us to discuss your care with your carer? You can change this at any time.

I consent to you discussing my care with my carer ☐

I <u>do not</u> consent to you discussing my care with my carer ☐

Any comments ……………………………………………………………………………………………

Are you a carer of a relative or friend? ☐ Yes ☐ No

Relationship to you: ……………………………………………..………………… (do not give name)

LANGUAGE SPOKEN

You are entitled to a free language interpreter if you need one (including British Sign Language)

Do you need a language interpreter? ☐ Yes ☐ No

If yes, please specify which language you speak:
……………………………………………………………….

Do you need other support with written or spoken English? ☐ Yes ☐ No

If yes, please indicate what type of support you need:
…………………………………………………………..

If you do not speak English, do you have a family member whom you are happy for us to contact by telephone when we need to contact you? If yes, please give details below:

Name: ……………………. …………………………… Relationship to you:
…………………….…………….

Telephone: ………………………………………….…… Mobile: ....

Do you consent to us discussing your care with the person named above? This can be changed at any time.

I consent to you discussing my care with the person above ☐
I do not consent to you discussing my care with the person above ☐

Any comments
……

YOUR ETHNIC GROUP

Knowing your ethnic group will help us identify who might be at greater risk from conditions such as heart disease, diabetes or sickle cell. To which of these ethnic groups do you feel you belong?

WHITE

☐ British ☐ Irish ☐ Albanian ☐ Any Other White
☐ English ☐ Welsh ☐ Bosnian
☐ Scottish ☐ Polish ☐ Kosovan

BLACK

☐ Black Caribbean ☐ Black British ☐ Nigerian
☐ Black African ☐ Somali ☐ Other Black

TRAVELLER

☐ Irish Traveller
☐ Gypsy

MIXED

☐ White & Black Caribbean ☐ Black & Asian
☐ White & Black Asian ☐ White & Black African
☐ White & Asian ☐ Other Mixed

ASIAN

☐ Indian	☐ East African Asian	☐ Chinese	☐ Armenian
☐ Pakistani	☐ Sri Lankan	☐ Iranian	☐ Afghan
☐ Bangladeshi	☐ Tamil	☐ Kurdish	☐ Any other Asian

I confirm that the above information is correct

Signed…………………………………………………. Date………………………………………...