Registration Form

Please return to Surgery Reception

BURTON CROFT SURGERY
. . . in the heart of Headingley

Title	Mr Mrs Miss Ms Mx
Surname	
First name (s)	
Date of Birth	
NHS number	
Gender	Male Female Non-binary Other (please specify):

Please choose your ethnicity from the list below:

British or mixed British (9i0)	☐	Indian or British Indian (9i7)	☐
White Irish (9i10)	☐	Pakistani or British Pakistani (9i8)	☐
Other white background (9i2)	☐	Bangladeshi or British Bangladeshi (9i9)	☐
White and Black Caribbean (9i3)	☐	Caribbean (9iB)	☐
White and Black African (9i5)	☐	African (9iC)	☐
Ethnic category not stated (9iG)	☐	Chinese (9iE)	☐

Other (please state):

Are you new to the UK? Do you require an interpreter?	Yes ☐ No ☐ Date of entry to the UK: If yes, what is your first language:
Address **(Please include block, flat and room number)**	
Contact Number	
Email address	

How would you like to be contacted? By email ☐ By text message ☐ By call ☐

If you have given us permission to contact you we will use your details to remind you of appointments, book reviews and follow-up tests. Information about health campaigns e.g. Flu, NHS Health Checks, along with any significant practice changes. You will also be able to give feedback on the quality of our services.

Place of birth (Town and country)	
Previous GP Practice	
Previous home address (including postcode)	

Staff use only Photo ID verification details (ID type and number if applicable, please sign and date)

 (Staff use only) Name:____ EMIS:___________ Date:__________

Nominated Pharmacy	Please state the pharmacy you would like any medication to be sent to below: If you are on repeat medication you **must** book an appointment with a GP or our practice pharmacist before you can order this.
Online Access	Please state if you would like online access (view test results, order prescriptions, book appointments) Yes ☐ No ☐
Next of Kin Information	Is your next of kin a patient at Burton Croft Surgery? Yes ☐ No ☐ Next of Kin name: ____________________________________ Relationship to you: __________________________________ Contact number (UK only): ____________________________ Is this person your emergency contact? Yes ☐ No ☐ Can this person discuss your medical record with us? Yes ☐ No ☐ Is this person a registered carer for you? Yes ☐ No ☐
Health Information	
	Height: cm Weight: kg
Smoking Status	Do you smoke? Yes ☐ No ☐ If yes, how many per day? ______ Have you ever smoked? Yes ☐ No ☐ If you are an ex-smoker, when did you stop? ___________
Are you a military veteran?	Yes ☐ No ☐ We are a veteran friendly practice, please ask for more information at reception if you need support.
Do you have any allergies? If yes please state:	Yes ☐ No ☐
Do you have any medical conditions or disabilities? If yes please state:	Yes ☐ No ☐
Have any of your blood relatives have suffered from the following: -Hypertension -Stroke -Heart attack -Diabetes -Breast or Ovarian Cancer	Yes ☐ No ☐ If yes, please state which member of your family, what did they/do they suffer from and what age were they diagnosed.
Do you help to look after someone who is ill, frail or disabled?	Yes ☐ No ☐ If Yes, who do you look after (e.g. partner, child, relative or friend?) ____ Do they live with you? Yes ☐ No ☐ Are they registered at this practice? Yes ☐ No ☐ Carers Leeds offers a confidential support and information service to carers. If you would like further information, please ask one of our receptionists for their leaflet.

 (Staff use only) Name:__________________________________ EMIS:__________ Date:__________

Burton Croft Surgery, 2nd Floor, Headingley Medical centre, St Michaels Court, 1 Shire Oak St, Leeds LS6 2AF

Health Visiting Service form

Families with children under 5 years please complete this form and hand in to reception.

The information on this form will only be shared with the health visiting team at Kirkstall Health Centre (telephone: 01138432700)

Current address including postcode:

Contact telephone number(s):

Your previous address (if applicable):

Previous GP (if applicable):

Adults in household

Adult/parent/carer 1 - Full Name: ____

Date of Birth: ________________________

Adult/parent/carer 2 - Full name: ____

Date of birth: ________________________

Children in household (*continue overleaf if necessary*.)

Child 1- Full name: ____

Date of birth: ______________________

Child 2- Full name: ____

Date of birth: ______________________

Child 3- Full name: ____

Date of birth: ____________________

Do your children have any special needs?

Do you have a social worker? YES/NO

Previous Health Visiting Team and Address (if known/applicable)

Do we need to use an interpreter when we speak to you? Yes/No

Family's first language:

 (Staff use only) Name:____ EMIS:___________ Date:__________