# DR. K. HICKS & DR. D. MCAULEY

## SPERRIN FAMILY PRACTICE

## *NEW PATIENT REGISTRATION INFORMATION FORM*

Surname: …… First Name: ……..
Known as: …….. Birth Name: ……
Marital Status (Mr, Mrs, Miss, Ms) Place of Birth/Ethnic Origin: ……
Address: ……
……
…… .. Postal Code: ……..
Telephone Number: …….. Mobile Number: ……
Preferred Pharmacy: ……
Dispensing (Plumbridge only - (DP1 Form completed) ……..

Height …….. Weight ……
Smoking: Current/Never/ExSmoker Alcohol: Units per week ……..
……..per day Beer/Spirits/Wine/Other
Blood Pressure(if known): …….. Date of last smear: ……

Allergies: ……
Medication: ……
……

**Do you consent to your basic info being held on 'Emergency Care Summary Record' i.e. Name, address, DO.B, current medication, allergies etc which can be shared for example with the Out Of Hours GPs, should you require their services?** **Yes/No**

**Do you consent to your patient held information being collected anonymously for use in research? (THIN- The Health Improvement Network)** **Yes/No**

**Do you care for a family member?** **Yes/No**

- **If you have answered 'yes' to the above question, as a new patient to the Practice, please make an appointment for an assessment of your needs as a carer**.

**Do you have a hearing difficulty?** **Yes/No**

- **Are you a sign language user?**
- **If Yes do you you use BSL (British Sign Language) or ISL (Irish Sign Language)** **BSL/ISL**