**Private Patient registration**

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| **Title** | **First names** | **Surname** | **Date of Birth** | **Emis number** |
| **Full Address and contact details**  House name and/or number ………………………………………………………………………………………………………………………………….  District or village name……………………………………………………………………………………………………………………………………………  Town……………………………………………………………………………………………………………………………………………………………………….  Post code………………………………………………………Landline…………………………………………………………………………………………..  Mobile…………………………………………………………email address……………………………………………………………………………………  Are you happy for us to contact you via email? Yes/No - Please circle the correct answer | | | | |
| **Registered GP details**  GP Name.................................................................................................................................................................  Surgery name……………………………………………………………………………………………………………………………………………………….  Surgery address……………………………………………………………………………………………………………………………………………………  Surgery telephone number if known………………………………………………………………………………………………………………….. | | | | |
| **Patients /parents signature………………………………………………………………….. Date**…………………………………………………  **PTO – there are questions on the reverse of this page to answer** | | | | |
| **Official use only**  **Emis record created -……………………………………………. Remember to add number at top of page**  **Patient here for:- (please tick which applies)**  **Travel vaccine…………………………………………………………………………Total cost………………………………………………………**  **Wart clinic ……………………………………………………………………………. Total cost………………………………………………………**  **HGV/LGV/PSV medical – fax number of pts registered surgery……………………………………………………………………….**  **Summary faxed to MCP**  **Remember :- Travel vaccines patient needs to complete a travel questionnaire**  **Wart clinic, first appointment must be 10 minutes.** | | | | |

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| **Medical questionnaire – please circle the correct answer and give details.**  Do you have any ongoing medical conditions Yes/No...................................................................................  Heart Problems Yes/No………………………………………………………………………………………………………………………………  Diabetes Yes/No…………………………………………………………………………………………………………………………………………  Respiratory problems Yes No ………………………….COPD……………………………..Asthma…………………………………….  Stroke/ TIA Yes/No…………………………………………………………………………………………………………………………………….  Any other current significant health problems?...........................................................................................  **Medication – Are you taking any prescribed medication Yes/No**  If Yes please list…………………………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………………………………………………….  …………………………………………………………………………………………………………………………………………………………………  …………………………………………………………………………………………………………………………………………………………………  ………………………………………………………………………………………………………………………………………………………………..  If you are having wart treatment – have you had treatment before Yes/No  If you are having ear syringing – have you had this treatment before Yes/No  Are you allergic or sensitive to any medication Yes/No -if yes please list……………………………………………………….  ……………………………………………………………………………………………………………………………………………………………………….  Have you any food allergies ………………………………………………………………………………………………………………………….  **LGV/HGV /PSV medicals – If your appointment is for one of these medicals and you are not a registered patient at this surgery, we do not have access to your GP medical notes. It would be helpful to the examining doctor to have an electronic summary of your notes. Please sign below to state you have given permission for us to ask your registered doctors surgery to email/fax us a copy.**  **I give permission for Mendip Country Practice to request an electronic copy of a summary of my GP medical notes**  **Signed ………………………………………………………………………………………………..Date…………………………………………..**  **Print Name…………………………………………………………………….Date of Birth…………………………………………………….** |