[](https://www.google.co.uk/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=2ahUKEwiYwrnOiIjcAhUGPhQKHYheAaEQjRx6BAgBEAU&url=https://twitter.com/rutherfordmc&psig=AOvVaw2mBGAqCUousv8RE0WNE7RZ&ust=1530883766358925)

**Helping us to help you.**

Title ………. Forename ………………………. Surname …………………………………………………….

Date of Birth ……………………………………………………………

Telephone ……………………………………………………………….

Mobile …………………………………………………………………….

Email address …………………………………………………………

Address ……………………………………………………………………………………………………………………………………………………………………………

Postcode ……………………………………………………………

Occupation …………………………………………………………

Height ………………………………………………………………

Weight ………………………………………………………………

Medical History (illnesses, serious accidents, operations)……………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………………………………

Current Medication …………………………………………………………………………………………………………………………………………….

……………………………………………………………………………………………………………………………………………………………………………

Allergies ………………………………………………………………………………………………………………………………………………………………

**Ethnic Group**

White British O Irish O Other O please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Black Caribbean O African O Other O Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asian Indian O Pakistani O Chinese O

Other O Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**From outside EEA and here to reside in or visit the UK**?

If you have been granted leave to enter or remain in the UK for a temporary period of more than six months, and have paid (or been exempted from paying) the Immigration Health Charge (also known as the “Surcharge”), or you believe that another exemption from charge category applies to you, please indicate this on the GP registration form. Please take documents with you to any hospital appointment to confirm your identity and any exemption you may have.

**Have any of your close family ever suffered from**: (please tick as applicable)

Diabetes 🞏 High Blood Pressure 🞏 Heart Disease 🞏 Asthma 🞏 Breast Cancer 🞏

Bowel Cancer 🞏 Other illnesses 🞏

Signed ………………………………………………………………………… Date …………………………………………………………………………………………