

SOMERSET BRIDGE MEDICAL CENTRE

Stockmoor Park Estate
Taunton Road
Bridgwater
Somerset TA6 6LD
Tel: 01278 411520
Fax: 01278 411539



May we take this opportunity to welcome you to Somerset Bridge Medical Centre and ask that you carefully read and complete the attached questionnaires listed below:

1. New Patient Health Questionnaire: (Please complete all fields)
2. Medication Request: (Only complete if you are currently taking medication)
3. Summary Care Record: Please read carefully and sign appropriately
4. If you come from abroad and have not registered in the UK before, please bring proof/copy of Immunisations.

ONCE COMPLETED, PLEASE HAND THE COMPLETED FORMS TO THE RECEPTIONIST WITH A FORM OF IDENTIFICATION AND CONFIRMATION OF YOUR CURRENT ADDRESS
We will not be able to process your registration without any of the above

Thank you for your co-operation

TO BE COMPLETED BY THE RECEPTIONIST

Appointment Arranged

Practice Booklet Given

Receptionist Signature

Date Forms Completed

Date Patient Registered

Dr D M Hynes MB BCh MSc FRCP(UK) DGM Dr S J Akhter FRC
Also
Redgate Medical Centre, Westonzoyland Road, Bridgwater, Somerset, TA6 5BF

REGISTRATION - PATIENT HEALTH QUESTIONNAIRE (CHILDREN UNDER 16)

Please complete this form on behalf of your child as fully as possible, as we are unable to complete your registration without this information

Surname Forenames

Previous Surname(s) (if any) NHS No:

Date of Birth Sex

Address

.....

Post code Telephone Number

PREVIOUS ADDRESS

.....

PREVIOUS GP

Place of Birth

Parent/Guardian/s Full Names

Parent/Guardian/s Address if different than patient's current Address

.....

What is your first language?

Ethnic Groups (please tick one option and delete as appropriate)

White – British/Irish/Other – please specify

Black – Caribbean/African/Other – please specify

Asian – Indian/Pakistani/Chinese/Other – please specify

Mixed – White & Black Caribbean/White & Black African/White & Asian/Other mixed – please specify

I DO NOT WISH TO GIVE THIS INFORMATION

Do you currently smoke? Yes/No If 'Yes' how many cigarettes a day

If no, have you ever smoked? Yes/No or ounces of tobacco a week

Please let us know if you would like smoking cessation advice

Did you have any problems at or around the time of birth?

Please list any health problems, serious illnesses, accidents, operations or disabilities:

.....

.....

Are you registered disabled? Yes/No If yes, please give details of your disability

.....

Height Weight

Immunisations

For children aged six and below, please give dates (or just a tick if dates are not known):

	First	Second	Third	Pre-School
Diphtheria, Tetanus, Polio
Pertussis (whooping cough)
Measles or MMR			

For Females Only

Rubella (German Measles)

HPV (Human Papilloma Vaccine)

Medicines (Please list any medications taken regularly)

.....

Are you allergic to any medicines and if so which?

Do you have any special milks or foods?

Do you suffer from any Allergies?
.....

If you suffer from Asthma, are you aware of any triggers that increase your asthma symptoms

.....

For Children with Chronic Disease Only (e.g. asthma, diabetes etc.)

Have you had a 'flu vaccination? Please enter date or 'never'

Have you had a pneumococcal vaccination? Please enter date or 'never'

Preferred Pharmacy

LLOYDS: Redgate Taunton Road Somerset Bridge North Petherton Victoria Park
 Superdrug Sainsburys Boots Quayside

Parent/Guardian Signature Date

PLEASE COMPLETE THIS PAGE IF YOU ARE CURRENTLY TAKING MEDICATION

Date:

Patients Full Name:

Patients Date of Birth:

Patients Previous Address:

Date of last prescription (if known):

Name & Address of Previous Surgery:

Telephone Number of Previous Surgery:

Fax Number of Previous Surgery: