

**REGENT HOUSE SURGERY REGISTRATION FORM**

Mr Mrs Miss Ms Surname

Date of Birth / / First Name

NHS No / / Previous surname

Male / Female Town & Country of birth

Home Address

Postcode Telephone number (Home)

 Telephone number (Mobile)

E-mail Address

**Is Patient within the Practice boundary** YES/NO

**Please help us trace your previous medical records by providing the following information.**

Your previous address in UK Name of previous doctor while at that address

 Address of previous doctor

**If you are registering a child under 5**

I wish/do not wish the child above to be registered with a doctor named at the Practice for Child Health Surveillance.

**Are you a carer Yes/No Do you have a carer Yes/No**

Name & Address of carer

Authorised Signature Date

**IF YOU ARE FROM ABROAD OR RETURNING FROM THE ARMED FORCES PLEASE TURN OVER**

**If you are from abroad** – Your first UK address where registered with a GP

If previously resident in UK - Date of leaving

Date you first came to live in UK

**If you are returning from the Armed Forces**

Address before enlisting

Service or Personnel number

Enlistment date

Official leaving date

**Ethnicity of Patient …………………………………………………………………………..**

PROOF OF ID SEEN

Driving Licence

Passport

Utility Bill

Bank Statement

Student Card/Credit Card

Other

DATE PATIENT REGISTERED ……………………………

PATIENT NUMBER ………………………………………….