Beacon Surgery Registration Details
Dependent Children

Name	
Date of Birth	
Communication Needs EG Deaf, Blind	
Address	
Pharmacy Nomination	Boots ☐ Morrisons ☐ Chappells ☐ Other……
Height	……..Feet ……Ins ……cms
Weight	……..Stone ……lbs ……..Kilos
Waist measurement	…….ins ……cms
Hip measurement	…….ins ……cms
Family History	Give Relationship and approx age when diagnosed
1. Heart Attacks, Angina	
2. Strokes	
3. Diabetes	
4. Asthma	
5. High Blood Pressure	
6. Cancer (Type of Cancer if known)	
7. Osteoporosis	
8. Glaucoma	
9. Thyroid problems	

Summary Care Record
This allows NHS Healthcare staff caring for you to be aware of your current medication, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Tick here to have a Summary Care Record ☐
Tick here for a form to opt out of a Summary Care Record ☐

Patient's Signature or on behalf of patient: Relationship of person completing form if not patient:	
For Surgery Use	
Photo ID:	Proof of Address:
Patients Usual Dr advised:	
Registration Accepted by:	
Pharmacy Completed:	

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If 16 or over please answer the following questions:

Smoking	
1. Do you smoke?	YES / NO
2. If no - have you ever smoked?	YES / NO Date Stopped……
3. Does anyone in your household smoke?	YES / NO

Alcohol Consumption

Question	Answers	Scores	Your Score
1. How often do you have a drink that contains alcohol?	Never Monthly or less 2-4 times per month 2-3 times per week 4+ times per week	0 points 1 point 2 points 3 points 4 points	
2. How many standard alcoholic drinks do you have on a typical day when you are drinking?	1-2 3-4 5-6 7-8 10+	0 points 1 point 2 points 3 points 4 points	
3. How often do you have 6 or more standard drinks on one occasion?	Never Less than monthly Monthly Weekly Daily or almost daily	0 points 1 point 2 points 3 points 4 points	

Scoring: A total of 5+ indicates hazardous or harmful drinking

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Patient's Name:…….

This practice, in line with other healthcare providers, collects information about the ethnic group of patients. This information can help us plan to meet the needs of the community and ensure that everyone has equal access to the healthcare we provide.

Please note we are not asking you about citizenship or nationality, but about the ethnic group to which you feel you belong.

All the information we receive will be used and treated with the strictest confidence. Any information used for service planning purposes will be anonymous with all the names and other identifying information removed.

The classification is entirely voluntary but will help provide a better service. If you do not wish to provide this information please tick the "not stated" box below.

If you have any queries about completing this form, please ask a staff member. Otherwise please complete the form below by ticking the appropriate box.

Ethnic group	Please Tick √
White: British	
White: Irish	
White: Any other White background	
Mixed: White and Black Caribbean	
Mixed: White and Black African	
Mixed: White and Asian	
Mixed: Any other mixed background	
Asian or Asian British: Indian	
Asian or Asian British: Pakistani	
Asian or Asian British: Bangladeshi	
Asian or Asian British: Any other Asian background	
Black or Black British: Caribbean	
Black or Black British: African	
Black or Black British: Any other Black background	
Other ethnic groups: Chinese	
Other ethnic groups: Any other ethnic group	
Not stated	