

New Croft Centre Registration

Date

NC	Old CASH No	Old GUM no									
Date of Birth: _____ Age: _____ Title: Mr / Mrs / Ms / Miss / Other Surname: _____ Marital Status: _____ Forename: _____ Ethnic Origin: _____ Country of Birth: _____ How would you like to be called from the clinic? Occupation: _____ First name Surname Patient number Nationality: _____ Address _____ NHS Number: _____ _____ _____ _____ Postcode: _____ Tel. No. Home: _____ Work: _____ Mobile: _____ Postcode: _____ Email address _____ <div style="text-align: right;">Overseas Visitor: Yes / No</div>											
For security reasons please give us a unique code word ie mothers maiden name, name of pet Question: _____ Answer: _____											
Our method of contacting you is by letter, what other method(s) can we use if we need to contact you regarding tests etc? Phone (Home) Yes/No PLEASE NOTE THAT WE OPERATE A TEXT SYSTEM FOR SENDING RESULTS Phone(Work) Yes/No Email Yes/No Mobile Yes/No GP: _____ Practice: _____ Previous attendance Yes/No Address: _____ <div style="text-align: right;">Can we contact your GP Yes/No</div>											
Were you referred to this service If so who by? Self <input type="checkbox"/> GP Advice <input type="checkbox"/> GP Letter <input type="checkbox"/> Health Advisor <input type="checkbox"/> Contact Slip <input type="checkbox"/> Contraception Clinic <input type="checkbox"/> Chlamydia Screening <input type="checkbox"/> Other <input type="checkbox"/> If other please state where: _____											
<div style="border: 1px solid blue; padding: 5px;"> Is your partner attending this clinic? Yes / No Name of Partner: _____ DOB _____ </div>											
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;"></td> <td style="width:25%; text-align: center;">Yes</td> <td style="width:25%; text-align: center;">No</td> </tr> <tr> <td>Was this your preferred clinic?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Do you have a current problem or symptoms?</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>				Yes	No	Was this your preferred clinic?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a current problem or symptoms?	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No									
Was this your preferred clinic?	<input type="checkbox"/>	<input type="checkbox"/>									
Do you have a current problem or symptoms?	<input type="checkbox"/>	<input type="checkbox"/>									
When did you first try to access this clinic? <input type="checkbox"/> Less than 2 working days <input type="checkbox"/> Over 2 working days <input type="checkbox"/> Over 1 week <input type="checkbox"/> Over 2 weeks											
signed:.....		date:.....									