E CARE HEALTH
WE ARE CARING FOR YOUR HEALTH

New Patient Registration Form

ASIA: COUNTRY:

HOSPITAL:

DIRECTOR:

Country:	**Patient/ Registration Number**
City:	**Attach Medical Report:** 1. **Medical history** 2. **All investigations copy to confirm diagnosis** 3. **Total cost**
DIAGNOSIS **History:**	
Estimated Cost: **Check to be addressed to:**	_____ **Director Signature** **Date**

Full Name:				**Date:** **Home Telephone Number:**			
Mr / Mrs / Miss / Ms / Other……..				**Work Telephone Number:**			
Address and Postcode:				**Mobile Telephone Number:**			
				Please indicate telephone contact number :			
				Email			
Date of Birth:	**Previous surname if different:**			**Patient's e-mail address:**			
Marital Status:		**Gender:**	**M / F**	**Do you agree to contact by e-mail?**			**Yes / No**
Your Occupation:				**Your Town & Country of Birth:**			
Your Next of Kin:	**Their Relationship to you:**						
Next of Kin Contact Number:				**Other residents of your home:**			
Names & Ages of Your Children:							
Your Previous Address:				**Your Pancard Number**			
				Previous Postcode:			
Your Previous Doctor Name & Address:				**Total cost of treatment.**			
				Annual household income			
If returning from Armed Forces:	**Your Service or Personnel Number:**			**Your last treatment Date:**			
Religion: *(Please tick one)*	**C of E**	**Catholic**	**Buddhist**	**Hindu**	**Muslim**	**Sikh**	
	Jewish	**Jehovah's Witness**		**No religion**	**Other religion** ***(please state)***		

PLEASE CONTINUE OVERLEAF

IF YOU ARE COMPLETING THIS FORM FOR YOUR CHILD PLEASE ALSO PROVIDE THE FOLLOWING INFORMATION SO THAT WE CAN FAMILY MATCH THEM TO YOUR RECORDS:

Child's previous name(s): ***Any changes of name will require official proof documentation***	**Child's Primary Doctor:**	**Primary Doctor's Address**
	Telephone No:	
Child's Previous address:	**Child's Mother's Name:**	**Child's Father's Name:**
	Child's Mother's Date of Birth:	**Child's Father's Date of Birth:**

Child's Current School:	Mother's Address *if different from Primary Carer's Address above*	Father's Address *if different from Primary Carer's address above*
Child's Previous School:		

tick one)	White (UK)	White (Irish)	White (Other)

African	Asian	Bangladeshi / British Bangladeshi	Chinese	Caribbean	Indian / British Indian
Indian / State	Other Asian Background	Other Black Background	Other Mixed Background	Other:	Ethnic Category not stated

Main or first language Spoken / Understood:	English	Hindi	German	Spanish	Polish	Other: *(Please Specify)*

DO YOU NEED TREATMENT PAYMENT? ***(a statement of what medical treatment you would not want in the future?)***

Yes / No	*Please give details*

Have you nominated someone to speak on your behalf	Yes / No	If "Yes", please state their name, address & phone no:

ARE YOU ADMITED INHOSPITAL BEFORE?

ADDRESS:	PHONE/EMAILContact Details:
	Signed: Date:

SUMMARY CARE RECORD

Do you have have Summary OF YOUR Record?	Yes No

Thank you for completing this form ~ please sign below

Signature of Patient	*Date:*

For more information about the services we offer, please refer to your

For office use only
Template
Completed Date: .....

FORM TO BE SCANNED

Please complete this confidential questionnaire in **BLOCK CAPITALS** and tick the boxes as appropriate.

PLEASE COMPLETE A SEPARATE FORM FOR EACH FAMILY MEMBER TO BE REGISTERED AND RETURN THEM TO THE HOSPITAL FOR THE E.HEALTH REGISTRATION WITH ANY DOCUMENTATION SPECIFIED. TO REGISTER WITH THE PRACTICE, YOU MUST COMPLETE BOTH THE PRACTICE AND THE E. HEALTH REGISTRATION FORMS