

# MILLRISE MEDICAL PRACTICE

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## Registration form for Stop Smoking Services Clients

*It is important that the forms is completed in full so that we can provide stop smoking services*

Personal Details	
Title	(Mr, Mrs, Miss or Other)
Forename	
Surname	
Address	
City	
County	
Post Code	
Telephone Number	
Mobile Telephone Number	
Date of Birth	
GP Name	
GP Address	
Gender (Male or Female)	Please Tick box <input type="checkbox"/> Male <input type="checkbox"/> Female

<p><b>Employment Status</b></p>	<p><b>Please Tick box</b></p> <p><input type="checkbox"/> Employed</p> <p><input type="checkbox"/> Unemployed</p> <p><input type="checkbox"/> Retired</p> <p><input type="checkbox"/> Student</p> <p><input type="checkbox"/> Other</p> <p>Please State Occupation:  .....</p>
<p><b>Ethnic Group</b></p>	<p><b>Please Tick Box</b></p> <p>White</p> <p><input type="checkbox"/> British</p> <p><input type="checkbox"/> Irish</p> <p><input type="checkbox"/> Other</p> <p>Mixed</p> <p><input type="checkbox"/> White and Black Caribbean</p> <p><input type="checkbox"/> White and Black African</p> <p><input type="checkbox"/> White and Asian</p> <p><input type="checkbox"/> Other</p> <p>Asian or Asian British</p> <p><input type="checkbox"/> Indian</p> <p><input type="checkbox"/> Pakistani</p> <p><input type="checkbox"/> Bangladeshi</p> <p><input type="checkbox"/> Other</p> <p>Black or Black British</p> <p><input type="checkbox"/> Caribbean</p> <p><input type="checkbox"/> African</p> <p><input type="checkbox"/> White and Asian</p> <p><input type="checkbox"/> Other</p> <p>Chinese or other ethnic group</p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Other</p>

<b>Temporary Address if different from one stated above</b>	
<b>Next Of Kin</b>	(Please give name, address and telephone number plus relationship to you)

It is important that we have full details of your medical history. Please answer yes or no if you suffer from any of the following :-

Epilepsy **Yes/No**

Depression **Yes/No**

Pregnant/Breast Feeding **Yes/No**

High Blood pressure **Yes/No**

Heart Disease/Angina **Yes/No**

Stroke Y/N

Asthma **Yes/No**

Skin Allergies **Yes/No**

Over active thyroid **Yes/No**

Renal/kidney Failure **Yes/No**

Chronic chest disease (COPD) **Yes/No**

Diabetes **Yes/No**

**Any other medical problems – please give details :-**

Do you take any regular medication - **Yes/No**  
**if yes please give details below**

## Client Notice

Please Note that although you are registering as a client for your stop smoking services you will need to see your own GP for all other health problems.

We are not liable for you to be seen by our GP's unless you are a registered patient with us.

Yours sincerely

Linda Allen  
Business Partner