High Mill Medical Practice
Drs Macleod, Lindsay, Thompson & Zonfrillo
Carluke Community Health Centre
40 Chapel Street
Carluke ML8 4BA
Tel No 01555 771012 Fax No 01555 777464

AGE BIRTH TO 14 YEARS INCLUSIVE

NEW PATIENT INFORMATION

SURNAME: …………………………. **FIRST NAME(S)**……………………………

FULL ADDRESS ………………………………………………………………

TEL NO. HOME: ……………………… **MOBILE NO** ………………………..

DATE OF BIRTH ………………………… **SEX MALE / FEMALE**

COUNTRY OF BIRTH: ………………………

NAME OF NEXT OF KIN ………………………………

RELATIONSHIP TO PATIENT ……………………………………………

CONTACT ADDRESS AND TELEPHONE NO ……………………………………….

PLEASE REMEMBER TO BRING SOME FORM OF IDENTIFICATION WITH YOU WHEN RETURNING YOUR FORMS TO THE RECEPTIONIST.

This can be :-

1 Medical Card
2 Birth Certificate
3 Passport

SIGNATURE ………………………….. **DATE** ………………………………….

Do you need an interpreter or sign language support?

Please circle YES NO

If you do need an interpreter what language do you speak?

Please state ………………………………………….

What is your ethnic group?
Choose ONE section from A to E then circle which best describes your ethnic group or background.

A. White
- Scottish
- English
- Welsh
- Northern Irish
- British
- Irish
- Gypsy / Traveller
- Polish
- Any other white ethnic group, please write in ……………………………

B. Mixed or Multiple ethnic groups
- Any mixed or multiple ethnic groups

C. Asian, Asian Scottish or Asian British
- Pakistani, Pakistani Scottish or Pakistani British
- Indian, Indian Scottish or Indian British
- Bangladeshi, Bangladeshi Scottish or Bangladeshi British
- Chinese, Chinese Scottish or Chinese British
- Other, please write in …………………………………………

D. African, Caribbean or Black
- African, African Scottish or African British
- Caribbean, Caribbean Scottish or Caribbean British
- Black, Black Scottish or Black British
- Other, please write in …………………………………………

E. Other ethnic group
- Arab
- Other, please write in …………………………………………..

If you do not wish to give this information please tick here ☐

Thank you for completing this form