OXLEY SURGERY
470 STAFFORD ROAD, WOLVERHAMPTON,
WEST MIDLANDS WV14 6PW
Tel: 01902 783103

THIS FORM IS TO BE COMPLETED BY PROSPECTIVE PATIENTS
Complete all sections otherwise we will be unable to process your request.

Date………………………………

Name(s)…………………………………………………………………………………

Date of Birth(s)……...

Current Address: ……………………………………………………………………....

…………………………………………………………………………………………

Telephone Number ……………………………Mobile…………………………………

Email……………………………………………………………………………….

PLEASE COMPLETE ALL THE QUESTIONS BELOW

1. Why are you applying to join this Practice?

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2. Have you applied to register with this practice in the past? YES / NO

3. We have an appointment system in operation. Do you find this acceptable? YES / NO

4. Do you have any family members or partner in the practice? YES / NO
If YES, please give name and relationship to you.

DO YOU SUFFER FROM ALLERGIES? Penicillin / Aspirin / others please specify…………

……………………………………………………………………………………………………

DO YOU SUFFER FROM ANY OF THE FOLLOWING MEDICAL CONDITIONS?

DIABETES	YES / NO	HIGH BLOOD PRESSURE	YES /NO
ANGINA / HEART PROBLEMS	YES / NO	EPILEPSY	YES / NO
THYROID PROBLEMS	YES / NO	ASTHMA	YES / NO

ANY OTHER MEDICAL CONDITIONS (Please State):

……………………………………………………………………………………………………

PTO

PLEASE PROVIDE DETAILS OF MEDICATION YOU ARE TAKING (Include dose and quantity or attach a printout)

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………

ARE YOU UNDER THE CARE OF A SPECIALIST? (Please provide details)

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……..

IF YOU HAVE A CARER PLEASE PROVIDE THEIR
NAME or AGENCY DETAILS INCLUDING TELEPHONE NUMBERS

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FOR OFFICE USE ONLY Date Received………………………………………………..

Accepted / Unable to Accept / Reason Given & Date …………………………………………………