Patient Registration Form

Clinic number _____

Sexual Health Dorset

Date of appointment		**Clinic:**

Your details

Surname	☐Mr ☐Mrs ☐Miss ☐Ms ☐Mx ☐Dr ☐Other
First name(s)	
What name would you prefer used when you are called from the waiting room?	
Any previous surnames?	
Date of birth:	
Do you have any disability or other problem we should be aware of?	☐ No ☐ Yes (please specify)
What is your gender?	☐ Male ☐ Female ☐ Other (describe) **Has this changed since birth?** ☐ No ☐ Yes
What is your sexuality?	☐ Heterosexual ☐ Lesbian woman ☐ Gay man ☐ Bisexual ☐ Pansexual ☐ Other
Home address	
Postcode	**Can we write to you at this address?** ☐ Yes ☐ No
Telephone number - home	**Can we contact you on this number?** ☐ Yes ☐ No
- mobile	**Can we contact you on this number?** ☐ Yes ☐ No
Royal Bournemouth DoSH:	To access your test results, you will need your clinic ID number. Telephone **01202 704 644** and select option 2.
Other sexual health clinics:	Test results will be sent to you by **text** message. If you do not have a mobile phone you will be asked to phone the clinic for results.

What is your marital status?	☐ Single ☐ Separated	☐ Married ☐ Civil partnership	☐ Living with partner ☐ Widowed	☐ Divorced
In which country were you born?				
What is your ethnic origin?	**White……** **Asian / Asian British…** **Black / Black British….** **Mixed ……...** **Other ethnic group …..**	☐ White British ☐ Indian ☐ Pakistani ☐ Black Caribbean ☐ White/Asian ☐ White/Black Caribbean ☐ Chinese	☐ White Irish ☐ Bangladeshi ☐ Black African ☐ White/Black African ☐ Other ethnic group	☐ Other White ☐ Other Asian ☐ Other Black ☐ Other Mixed
What is your occupation?				
If you are a student, which school / college do you attend?				

Your GP and referral details

Who is your GP?	
Which surgery do you attend?	
Can we tell your GP if necessary about any treatment you have received at this clinic? *Note: We will **not** pass on information to your GP without your consent, **unless** you are diagnosed with a serious infection that requires treatment, and we have been unable to contact you to arrange this.*	☐ Yes ☐ No
Do you wish to receive a copy of any letters sent to your GP or another specialist?	☐ Yes ☐ No

Who referred you to this clinic?	☐ Self ☐ Partner ☐ Other sexual health clinic ☐ GP – with referral letter ☐ GP advice – no letter	☐ Health adviser (letter) ☐ Health adviser (phone or text) ☐ Drugs Advisory Service ☐ Sexual Assault Referral Centre ☐ School nurse	☐ Pharmacy ☐ Midwife ☐ Gynaecologist ☐ Other hospital specialist ☐ Other
When did you first try to make an appointment at this clinic?	☐ Today ☐ Less than 2 days ago	☐ Between 2 days and 1 week ago ☐ Between 1 and 2 weeks ago	☐ More than 2 weeks ago ☐ Appt was posted to me
Have you attended a sexual health clinic in this area before?	☐ No ☐ Yes (please say where)		
Which clinic would you prefer to attend, given the choice?	☐ This clinic ☐ A clinic elsewhere (please say where)		

Thank you for completing this CONFIDENTIAL form. Please sign & hand it back to the receptionist.

Signature _____ **Date** _____