



Patient's details

Please complete in BLOCK CAPITALS and tick  as appropriate

Mr    Mrs    Miss    Ms   Surname \_\_\_\_\_  
 Date of birth | | | | | | | | | | First Names \_\_\_\_\_  
 NHS No | | | | | | | | | | Previous surnames \_\_\_\_\_  
 Male    Female   Town and country of birth \_\_\_\_\_  
 Home address \_\_\_\_\_

Postcode \_\_\_\_\_ Telephone number \_\_\_\_\_

Please help us trace your previous medical records by providing the following information

Your previous address in the UK \_\_\_\_\_ Name of previous doctor while at that address \_\_\_\_\_

Address of previous doctor \_\_\_\_\_

If you are from abroad  
Your first UK address where registered with a GP \_\_\_\_\_

If previously resident in the UK, date of leaving \_\_\_\_\_ Date you first came to live in UK \_\_\_\_\_

If you are returning from the Armed Forces  
Address before enlisting \_\_\_\_\_

Service or personnel number \_\_\_\_\_ Enlistment Date \_\_\_\_\_

If you are registering a child under 5

I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances\*

I live more than 1 mile in a straight line from the nearest chemist

I would have serious difficulty in getting them from a chemist

\*Not all doctors are authorised to dispense medicines

What is your ethnic group? Please tick ONE box only.

White British                                       White Irish  
 Any other White background - please write details here: \_\_\_\_\_

Mixed White and Black Caribbean     Mixed White and Black African                       Mixed White and Asian  
 Any other mixed background - please write details here: \_\_\_\_\_

Asian or Asian British: Indian                       Asian or Asian British: Pakistani                       Asian or Asian British: Bangladeshi  
 Any other Asian or Asian British background - please write details here: \_\_\_\_\_

Black or Black British: Caribbean                       Black or Black British: African  
 Any other Black or Black British background - please write details here: \_\_\_\_\_

Chinese  
 Any other ethnic group - please write details here: \_\_\_\_\_

What is your first language? \_\_\_\_\_  
(If a minor the first language is that of parent/guardian)

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**YOUR HEALTH**

Do you smoke?      YES/NO      How many cigarettes/oz tobacco?: .....

**If you do smoke, please STOP as smoking will damage your health**  
**If you need help or advice to stop smoking please see your GP**  
**NHS Smoking Helpline: 0800 1690169**

Do you drink alcohol?   YES/NO      How many units per week? ..... ( 1 unit = ½ pint of beer  
Or 1 measure of spirit  
Or 1 small glass of wine)

Do you take any regular sport? ..... (Please grade yourself on a scale 1 to 10 – (1 = avoid even trivial exercise  
10 = competitive athlete)

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Signature of patient       Signature on behalf of patient

Date

Please see overleaf for Organ donation

*Please Turn Over*

**NHS Organ donor registration**

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

- Any of my organs and tissue or  Kidneys  Heart  Liver  Corneas  Lungs  Pancreas

Signature confirming my agreement

to organ/tissue donation: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

For more information, please ask at reception for an information leaflet or visit the website [www.uktransplant.org.uk](http://www.uktransplant.org.uk) or call 0845 60 60 400

**NHS blood donor registration**

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years

Signature confirming consent to inclusion on the NHS Blood Donor Register:

\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

For more information, please ask for the leaflet on joining the NHS Blood Donor Register

My preferred address for donation is: (only if different from overleaf, eg your place of work)

\_\_\_\_\_ Postcode \_\_\_\_\_

**To be completed by the doctor**

Doctor's Name

HA Code

- I have accepted this patient for general medical services  
 For the provision of contraceptive services  
 I have accepted this patient for general medical services on behalf of the doctor name below who is a member of this practice

Doctor's Name, if different from above

HA Code

- I am on the HA CHS list and will provide Child Health Surveillance to this patient or  
 I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS and will provide Child Health Surveillance to this patient

Doctor's Name, if different from above

HA Code

- I will dispense medicines/appliances to this patient subject to Health Authority Approval

- I am claiming rural practice payment for this patient  
 Distance in miles between my patient's home address and my main surgery is

*I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission*

Authorised Signature

Name

Date

Practice Stamp

*Please Turn Over*