



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)

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)

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 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