

Patient's details

Please complete in **BLOCK CAPITALS** and tick as Appropriate

| | | | | | | | | | |
|---|------------------------------|---------------------------------|---|---------------------------|---|---|---|--------------------|-------------|
| <input type="checkbox"/> Mr | <input type="checkbox"/> Mrs | <input type="checkbox"/> Miss | <input type="checkbox"/> Ms | Surname | | | | | |
| Date of birth | | | d | d | m | m | y | y | First names |
| NHS No. | | | | | | | | Previous surname/s | |
| <input type="checkbox"/> Male | | <input type="checkbox"/> Female | | Town and country of birth | | | | | |
| | | | | Ethnic Origin | | | | First Language | |
| Home address | | | | | | | | | |
| | | | | | | | | | |
| Postcode | | | Telephone No: | | | Mobile No: | | | |
| Are you a carer? <input type="checkbox"/> | | | Do you have a carer? <input type="checkbox"/> | | | Are you registered Disabled? <input type="checkbox"/> | | | |

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

| | |
|-----------------------------|---|
| Your previous address in 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 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 | Date Left |

If you are registering a child under five.

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.*

Signature of Patient **Signature on behalf of patient** Date

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 three 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 above e.g. your place of work)

..... Postcode

To be completed by the doctor

Doctors Name

HA code

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

Doctors 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 list, and will provide Child Health Surveillance to this patient.

Doctors name, if different from above

HA code

I will dispense medicines/appliances to this patient, subject to Health Authority's 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

Practice Stamp

Name

Date

HA use only Patient registered for: GMS CHS Dispensing Rural Practice



Meeting Everyone's Health Needs

We would be very grateful if you could take time to complete this form. Please be assured that any information given will be treated confidentially. If you have any queries about completing this form, please ask a member of staff. For question 1, if you feel you are descended from more than one group, please tick the one you feel you most belong to or choose the "Any Other Ethnic Group" option. We are also asking your religion, preferred language, whether you have a disability, your smoking and alcohol status, if you are a Carer and BMI (height and weight). Again this is to help us ensure we meet your health care needs appropriately.

When you have completed the form, please return with the enclosed registration. Thank you.

What is your Ethnic Group? Choose ONE section only

White

- British
- Irish
- Any Other White background (please state)

Mixed

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other Mixed background (please state)

Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- Any other Asian background (please state)

Black or Black British

- Caribbean
- Africa
- Any other Black background (please state)

Any Other Ethnic Group

- Chinese
- Vietnamese
- Any Other (please state)
- Do not wish to state

Do you have a disability/impairment (e.g. Hearing, Vision, Mobility) Yes No

Details

.....
.....

Please turn over and complete all sections - Thank you

What is your Religion (tick one box only)

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Church of England | <input type="checkbox"/> Roman Catholic |
| <input type="checkbox"/> Christian | <input type="checkbox"/> Buddhist | <input type="checkbox"/> Hindu |
| <input type="checkbox"/> Jewish | <input type="checkbox"/> Islam | <input type="checkbox"/> Jehovah's Witness |
- Other (please state)
- Do not wish to state

What is Your Preferred Language (Please choose ONE)

| | Spoken | Written |
|-----------------------|--------------------------|--------------------------|
| English | <input type="checkbox"/> | <input type="checkbox"/> |
| Vietnamese | <input type="checkbox"/> | <input type="checkbox"/> |
| Chinese | <input type="checkbox"/> | <input type="checkbox"/> |
| Hindi | <input type="checkbox"/> | <input type="checkbox"/> |
| Panjabi | <input type="checkbox"/> | <input type="checkbox"/> |
| Urdu | <input type="checkbox"/> | <input type="checkbox"/> |
| Cantonese | <input type="checkbox"/> | <input type="checkbox"/> |
| British Sign Language | <input type="checkbox"/> | <input type="checkbox"/> |

Other (please state)

Please Enter Your Smoking Status

- Never Smoked Current Smoker - amount per day =

Ex Smoker - Please Enter Date Stopped

- Ex Light Smoker (1 to 9 per day) Date Stopped
- Ex Moderate Smoker (10 to 19 per day) Date Stopped
- Ex Heavy Smoker (20 to 39 per day) Date Stopped
- Ex Heavy Smoker (40 + per day) Date Stopped

If you are a **Current Smoker** and would like help in stopping - please tick this box so that we can offer you help with this.

Height

Weight

Alcohol Intake

How often do you have a drink containing Alcohol?

- Never Monthly or less 2-4 times / Month
- 2-3 times / Week 4 + time / Week

How many Standard drinks containing Alcohol do you have on a typical Day?

- None 1 or 2 3 or 4 5 or 6
 7 to 9 10 or more

How often do you have six or more drink on one occasion?

- Never Less than Monthly Monthly
 Weekly Daily or almost Daily

In order for us to update your Clinical Records accurately, please complete the following:

Surname First Name(s).....

Address

Postcode Date of Birth

Telephone Number Mobile No.

Date

Next of Kin (please complete the following)

Surname First Name(s).....

Address

Postcode Date of Birth

Telephone Number Mobile No.

Date

Please inform us IMMEDIATELY of any changes of Address or Phone Numbers

Thank you for completing this form