

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 surname/s: _____

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 UK: _____ Name of previous GP practice while at that address: _____

Address of previous GP practice: _____

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: _____

Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: Regular Reservist Veteran Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting: _____

Service or Personnel number: _____ Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable) Postcode: _____

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

I live more than 1.6km in a straight line from the nearest chemist

I would have serious difficulty in getting them from a chemist

Signature of Patient Signature on behalf of patient

**Not all doctors are authorised to dispense medicines*

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 consent to join the NHS Organ Donor Register: _____ Date: ____/____/____

Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit www.organdonation.nhs.uk or call 0300 123 23 23 to register your decision.

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 my consent to join the NHS Blood Donor Register: _____ Date: ____/____/____

My preferred address for donation is: (only if different from above, e.g. your place of work) _____

All blood types are needed, especially O negative and B negative. Visit www.blood.co.uk or call 0300 123 23 23. Postcode: _____

NHS England use only Patient registered for GMS Dispensing

To be completed by the GP Practice

Practice Name

Practice Code

I have accepted this patient for general medical services on behalf of the practice

I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Practice Stamp

Authorised Signature

Name

Date ____/____/____

SUPPLEMENTARY QUESTIONS - These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice. However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK. Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges. More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

Please tick one of the following boxes:

- a) I understand that I may need to pay for NHS treatment outside of the GP practice
- b) I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested
- c) I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		Date:	
Print name:		Relationship to patient:	
On behalf of:			

Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC), DETAILS and S1 FORMS

Do you have a non-UK EHIC or PRC?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	If yes, please enter details from your EHIC or PRC below:
Country Code: <input type="text"/>		
3: Name		
4: Given Names		
5: Date of Birth		
6: Personal Identification Number		
7: Identification number of the institution		
8: Identification number of the card		
9: Expiry Date		
PRC validity period	(a) From: <input type="text"/>	(b) To: <input type="text"/>

If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.

Please tick if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). Please give your S1 form to the practice staff.

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

Preston Grove Medical Centre Health Status for New Patients

Welcome to our practice. It can take a while for your previous GP records to reach us, it helps to have some basic details about your health in the meantime.

Date:

Registration Details

Name	
Date of birth	
Address	
Landline number	
Mobile number	
Email address	
Have you been registered here before?	
Name and address of previous surgery	

Medication

Please provide the print out of your current repeat prescriptions from your previous surgery, this can be found on the green slip you receive when collecting your medication from the pharmacy. Alternatively, please list below.

Please note: You may need to see a GP for some medication requests.

Name of medication	Strength of medication	Daily dosage

Lifestyle Profile (18 years and over only)

Please answer the following questions appropriately:

When was your last Tetanus vaccination?

When was your last cervical screening and the results? (N/A to all patients)

.....

How many units of alcohol do you consume per week?

Do you have a healthy diet? YES NO

Do you enjoy exercise? NO LIGHT MODERATE HEAVY

Family History Taken

Have any of your family members developed any of the following conditions before the age of 65? Where possible please indicate what type.

Condition	Please specify	Yes/No	Which family member?
Myocardial Infarct			
Cardiovascular Disease			
Hypertension			
Aortic Aneurysm			
High Blood Fat			
DVT/Thrombosis			
Diabetes			
Asthma			
Osteoporosis			
Glaucoma			
Cancer			

Ethnicity

This information is optional, if you wish to decline please tick this box.

Information on ethnicity is important as we need to take into account culture, religion and language in providing appropriate healthcare and the need to demonstrate equal outcomes for all our patients.

Please tick the ethnic category which you feel you best fit into:

- | | | | |
|------------------------------------|--------------------------|--------------------------------|--------------------------|
| British or Mixed British | <input type="checkbox"/> | White and Black Caribbean | <input type="checkbox"/> |
| Irish | <input type="checkbox"/> | White and Black African | <input type="checkbox"/> |
| Other White | <input type="checkbox"/> | White and Asian | <input type="checkbox"/> |
| Other Mixed Background | <input type="checkbox"/> | Indian or British Indian | <input type="checkbox"/> |
| Bangladeshi or British Bangladeshi | <input type="checkbox"/> | Pakistani or British Pakistani | <input type="checkbox"/> |
| Chinese | <input type="checkbox"/> | Other Asian | <input type="checkbox"/> |
| Other Black background | <input type="checkbox"/> | Other | <input type="checkbox"/> |

Please answer the following:

What is your country of birth?

Is your main spoken language English? YES NO

If no, please specify your main spoken language

Will you need an interpreter for your appointments?

Physical Examination and Smoking Status

Please answer the following, where possible:

Recent blood pressure reading

Recent pulse rate

Height (in cm)

Weight (in kg)

Do you smoke? YES NO

If yes, how many? (per day)

Would you like help to stop smoking? YES NO

Are you an ex-smoker? YES NO

If yes, how many? (per day)

Carers

Please answer the following:

Are you a carer? (Do you look after a relative or friend, or are you cared for?)

YES NO

If yes, please specify details below to enable us to provide support and help

.....

Do you have any close relatives already registered to the practice? YES NO

Alcohol Screening (18 years and over only)

Please mark the box which you feel best relates to you.

(1 drink= 1 pint of beer, 1 glass of wine or 1 single spirit)

	Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily or almost daily (4)
<u>MEN ONLY</u> : How often do you have EIGHT or more drinks on one occasion?					
<u>WOMEN ONLY</u> : How often do you have SIX or more drinks on one occasion?					
How often in the past year have you been unable to remember what happened the night before due to drinking?					
How often in the past year have you failed to do what was expected of you due to drinking?					

	No (0)	Yes, on one occasion (2)	Yes, on more than one occasion (4)
In the last year, has a friend/relative/doctor or any other health care worker been concerned about your drinking or suggested you cut down?			

SCORE:

Thank you for your time in completing our health status questionnaire for new patients, please attach this to your registration form and return to the practice.