

## 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				First names			
NHS No.				Previous surname/s			
<input type="checkbox"/> Male <input type="checkbox"/> 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 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			

## 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\*

*\*Not all doctors are authorised to dispense medicines*

- 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

Signature of Patient    Signature on behalf of patient   Date

### NHS Organ Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate

- Kidneys  
  Heart  
  Liver  
  Corneas  
  Lungs  
  Pancreas  
  Any part of my body

*Signature confirming consent to organ donation*

*Date*

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

### 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 above, e.g. your place of work)

Postcode: .....

## To be completed by the doctor

Doctors 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 named below who is a member of this practice

Doctors Name, if different from above

HA Code

- I am on the HA CHSlist 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

Name

Date

Practice Stamp

## Goodinge Group Practice – New Patient Registration Questionnaire

This information will help us whilst we await receipt of notes from your previous doctor. Please be as accurate as possible.

### REGISTRATION INFORMATION

Patient name:	Date of birth
Mobile number (for text message reminders)	Email address (for email reminders – when available)
Are you a carer? For whom?	Children of school age <u>please state name of school</u>
Do you have a carer?	Next of kin name, address and contact number (for contact in emergency)
Do you speak English?	What is your main language?

### ETHNICITY PLEASE TICK

<b>White</b> <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other white background Please state
<b>Black or Black British</b> <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Any other Black background Please state
<b>Mixed</b> <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Asian <input type="checkbox"/> Any other mixed background Please state
<b>Asian or Asian British</b> <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Any other Asian background Please state
<b>Other Ethnic Group</b> <input type="checkbox"/> Chinese <input type="checkbox"/> Any other Ethnic group Please state

### LIFESTYLE INFORMATION

Do you drink alcohol? YES <input type="checkbox"/> NO <input type="checkbox"/>	How many units per week?
Height:	Weight:

**MEDICAL INFORMATION**

Please turn over

**Do you or any of your family have a history of the following medical conditions?**

	<b>You</b> (please tick)	<b>Year of onset</b>	<b>Family Member?</b> (Sister, father for example)	<b>Approximate age of onset</b>
Heart disease e.g. heart attack, angina, heart failure (please state which)				
Stroke				
Diabetes				
Asthma or chronic breathing problems				
High blood pressure				
Epilepsy				
Thyroid problems				
Mental health problems				
Alzheimer's or Dementia				
Cancer (please tick)			Family Member?	Approximate age of onset
What part of the body?		Age of onset	Which part of the body?	
Any other relevant past or current medical history?				

Have you had any major illnesses or operations?	Please give details and dates if you can.
Do you have any allergies?	
If you are female aged 25 or over, when did you have your last smear test?	
Where was this taken?	Result if known

**THANK YOU**