

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

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

	You (please tick)	Year of onset	Family Member? (Sister, father for example)	Approximate age of onset
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