NHS Family Doctor Services Registration – please complete both sides of form

Patient's Details *please complete in BLOCK CAPITALS and ☑ as appropriate*

Surname		**First Name(s)**	

Previous Surname		**Date of Birth**	

☐ Mr	☐ Mrs	☐ Miss	☐ Ms	☐ Male	☐ Female

Town and Country of Birth:	**Tel No:** **email address:**

Home Address
inc Post Code

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 GP ………………………………………………………………………………………………………

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 for Child Health Surveillance

TO BE COMPLETED BY THE DOCTOR

Doctor's Name		**HA Code**

☐ I have accepted this patient for general medical services

☐ For the Provision of contraception service

☐ I have accepted this patient for general medical services on behalf of the doctor named 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 list 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'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.

DOCTOR'S SIGNATURE:		**DATE:**

PTO

GENERAL

Please tell us if you have any Allergies					
Height			**Weight**		
Do you Smoke?	Yes ☐	No ☐	Ex Smoker ☐	Date stopped?	If **YES** how many per day?

ALCOHOL QUESTIONNAIRE (please tick)

Do you drink alcohol?	**Yes** ☐	**No** ☐	If **YES** how many units per week?		
How often do you have 8 (men)/6 (women) or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost Daily
Only answer the following questions if your answer above is monthly or less					
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost Daily
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost Daily
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No	Yes, but not in the last year		Yes, during the last year	

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 ……………………………………………………………………………..

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…………………………………………please ask for the leaflet on joining the NHS Blood Donor Register

FIRST SPOKEN LANGUAGE	

Patient Ethnic Questionnaire Please indicate your ethnic origin. This is not compulsory but may help with your healthcare as some health problems are more common in specific communities and knowing your origins may help with the early identification of some of these conditions. Please tick ☑

White	British ☐	Irish ☐	Any other white background (please state)	
Mixed	White and Black Caribbean ☐	White and Black African ☐	Any other mixed background (please state)	
Asian or Asian British	Indian ☐	Pakistani ☐	Bangladeshi ☐	Any other Asian background, (please state)
Black or Black British	Caribbean ☐	African ☐	White and Asian ☐	Any other Black background (please state)
Chinese or Other Ethnic Group	Chinese ☐			Any other (please state)

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