



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 doctor 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*

- 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 Donation registration

I would like to join the NHS Organ Donation 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 who would be prepared to give 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 your 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 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
- 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.

Authorise Signature

Name

Date

Practice Stamp



Downing Street Group Practice

4 Downing Street, Farnham, Surrey, GU9 7PA
Tel: 01252 716226 Fax: 01252 717076

NEW PATIENT PRACTICE REGISTRATION & HEALTH CHECK FORM

Please ensure you also complete the required NHS New Patient Registration Form

UNDER 15's ONLY

Dear Patient,

Welcome to the practice.

Please answer the following questions. It is essential that your new Doctor has some basic information about you as it can take some weeks for your previous records to arrive.

Date of registration

SurnameFirst Names

AddressPostCode

Date of Birth Height Weight

Home Telephone NumberMobile

ETHNICITY - Please circle the appropriate ethnic group.

- | | | | | | |
|---|---------------------|---|-------------------|---|-----------------|
| A | BRITISH | B | IRISH | C | ANY OTHER WHITE |
| D | WHT & BLK CARIBBEAN | E | WHT & BLK AFRICAN | F | WHITE & ASIAN |
| G | ANY OTHER MIXED | H | INDIAN | I | PAKISTANI |
| J | BANGLADESHI | K | ANY OTHER ASIAN | L | CARIBBEAN |
| M | AFRICAN | N | ANY OTHER BLACK | O | CHINESE |

Current School

Previous Home Address

.....PostCode

Previous GP Address

..... PostCode

Do you are for anyone who is chronically ill? **Yes / No** Is yes, who do you care for?

SMOKING HISTORY

Are you a current smoker? **Yes / No** If yes, how many per day?

ALCOHOL

Do you consume alcohol? **Yes / No** If yes, how much per week?

DO YOU SUFFER FROM ANY ALLERGIES?

Drug allergy (please specify which drug/s)

Non drug allergy (please specify)

YOU MUST MAKE AN APPOINTMENT WITH A DOCTOR IF YOU ARE ON ANY MEDICATION BEFORE A PRESCRIPTION CAN BE ISSUED. PLEASE BRING YOUR MEDICATION WITH YOU.

Please note that the practice **does not** discriminate on the grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.