



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

Practice Stamp

Name

Date



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

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. Please make an appointment for a health check with the Practice Nurse. It is also an opportunity to discuss health issues and screen for potential problems eg cholesterol, diabetes and high blood pressure.

This examination is not necessary for children under 5 years of age.

Date of Registration

Surname First Name

Address PostCode

Date of Birth Home Tel Number Work/Mobile.....

Present Occupation (previous is retired or not working)

Marital Status Weight Height

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 |

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

You must make an appointment with a Doctor/Nurse Practitioner if you are on any medication before a prescription can be issued and please bring your medication with you.

SMOKING HISTORY

Are you a current smoker? **Yes / No** If yes, how many per day? Would you like help to stop? **Yes / No**

Are you an ex-smoker? **Yes / No** When did you stop? Never smoked (tick if appropriate)

ALCOHOL

How much alcohol do you consume per week?

DO YOU SUFFER FROM ANY ALLERGIES? Yes / No

Drug allergy (please specify)

Non drug allergy

Remember, you MUST make an appointment with your new doctor if you are on any medication.



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ABOUT YOU AND YOUR FAMILY

HAVE ANY FAMILY RELATED MEMBERS SUFFERED FROM ANY OF THE FOLLOWING?

Condition

Relation

At What Age?

Alive / Dead

Heart Attack

Angina

Other Heart Problem

(Please specify)

Diabetes

Asthma

Cancer

High Blood Pressure

Epilepsy

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**REGISTRATION CHECK - MAKE AN APPOINTMENT NOW AS THE CHECK
NEEDS TO BE DONE IN THE NEXT 6 WEEKS.**

Non-Discrimination Policy

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.

REQUEST

**PLEASE COULD NEW PATIENTS DELIVER THEIR FORMS IN PERSON WITH IDENTIFICATION OF
A PASSPORT AND A UTILITY BILL.**

ALSO, IT HELPS RECEPTION IF NEW PATIENTS COULD ATTEND IN THE AFTERNOON IF POSSIBLE.

THANK YOU



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ALCOHOL USE IDENTIFICATION TEST

As part of our Health Service it is important to examine lifestyle issues likely to affect the health of our patients. This information will assist in our giving you the best treatment. Therefore, we ask that you complete this questionnaire that asks about your use of alcoholic beverages during the past year.

Please answer as accurately and honestly as possible.

All information will be treated in strict confidence.

1. How often do you have a drink containing alcohol?

- 0 points – Never
- 1 point – Monthly or less
- 2 points – 2 to 4 times a MONTH
- 3 points – 2 to 3 times a WEEK
- 4 points – 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

- 0 points – 1 or 2 drinks
- 1 point – 3 or 4 drinks
- 2 points – 5 or 6 drinks
- 3 points – 7, 8 or 9 drinks
- 4 points – 10 or more drinks

3. How often do you have six or more drinks on one occasion?

- 0 points – Never
- 1 point – Less than monthly
- 2 points – Monthly
- 3 points – Weekly
- 4 points – Daily or almost daily