

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 want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

Any of my organs and tissue or

Kidneys Heart Liver Corneas Lungs Pancreas Any part of my body

Signature confirming my agreement to organ/tissue donation Date _____ / _____ / _____

For more information, please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk, or call 0300 123 23 23.

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: _____

HA use only Patient registered for GMS CHS Dispensing Rural Practice

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 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 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.

Practice Stamp

Authorised Signature

Name Date ____/____/____

SUPPLEMENTARY QUESTIONS

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice. However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

Please tick one of the following boxes:

- a) I understand that I may need to pay for NHS treatment outside of the GP practice
 b) I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested
 c) I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		Date:	DD MM YY
Print name:		Relationship to patient:	
On behalf of:			

Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS

Do you have a non-UK EHIC or PRC?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	If yes, please enter details from your EHIC or PRC below:
 <p><i>If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.</i></p>	Country Code:	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	DD MM YYYY
	PRC validity period (a) From:	DD MM YYYY

Please tick if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff.**

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

Thornfield Medical Group New Patient Questionnaire

Patient Name: _____

Mobile Number: _____ Can we text you: Yes () No ()

Home Number: _____ Email Address: _____

Allergies if any _____

Nationality/Ethnicity: _____ 1st Spoken Language _____

Height _____ Weight _____

Do any of your family have health problems? If yes, please tell us which member(s) of your family and their health problems? _____

Next of Kin's name and relationship _____

Next of Kin's telephone number _____

Do you have a Carer? Yes () No () Are You a Carer? Yes () No ()

Name _____

Telephone Number _____

Do you smoke? Yes () No (). How much do you smoke? _____

If YES, would you like help to stop? Yes () No ()

Are you a Military Veteran? Yes () No ()

Would you like to opt - out of Summary Care Record? Yes () No ()

Would you like to join our Patient Representation Group? Yes () No ()

Drinking Survey – Please circle the most appropriate response for you

How often do you have a drink containing alcohol? (Audit C)

Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
Points (0)	(1)	(2)	(3)	(4)

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

1 or 2	3 or 4	5 or 6	7-9	10 or more
Points (0)	(1)	(2)	(3)	(4)

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

Never	Less than Monthly	Monthly	2-3 times a week	4 or more times a week
Points (0)	(1)	(2)	(3)	(4)

Please add up your scores = score: _____

If score is 5 or more please turn over and complete the second part of the questionnaire.

Drinking Survey Part 2- Please circle the most appropriate response for you

How often during the last year have you found that you were not able to stop drinking once you had started?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Points (0)	(1)	(2)	(3)	(4)

How often during the last year have you failed to do what was normally expected from you because of your drinking?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Points (0)	(1)	(2)	(3)	(4)

How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy session?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Points (0)	(1)	(2)	(3)	(4)

How often during the last year have you had a feeling of guilt or remorse after drinking?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Points (0)	(1)	(2)	(3)	(4)

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Points (0)	(1)	(2)	(3)	(4)

Have you or someone else been injured as a result of your drinking?

Never		Yes but not in the last year		Yes during the last year
Points (0)	(1)	(2)	(3)	(4)

Has a relative or friend or doctor or other health worker been concerned about your drinking or suggested you cut down?

Never		Yes but not in the last year		Yes during the last year
Points (0)	(1)	(2)	(3)	(4)

Please add your scores. Total score: _____

**Please return completed Questionnaire to the Receptionist
Many thanks for your co-operation**