

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 GP practice while at that address
	Address of previous GP practice

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

Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: ☐ Regular ☐ Reservist ☐ Veteran ☐ Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting:	Postcode
Service or Personnel number:	Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

☐ I live more than 1.6km in a straight line from the nearest chemist ☐ I would have serious difficulty in getting them from a chemist	<i>*Not all doctors are authorised to dispense medicines</i>
☐ 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

Signature confirming my consent to join the NHS Organ Donor Register Date ____/____/____

Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit www.organdonation.nhs.uk or call 0300 123 23 23 to register your decision.

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 my consent to join the NHS Blood Donor Register Date ____/____/____

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode: _____
All blood types are needed, especially O negative and B negative. Visit www.blood.co.uk or call 0300 123 23 23.

NHS England use only Patient registered for ☐ GMS ☐ Dispensing

To be completed by the GP Practice

Practice Name

Practice Code

☐ I have accepted this patient for general medical services on behalf of the practice

☐ I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Practice Stamp

Authorised Signature

Name

Date ____/____/____

SUPPLEMENTARY QUESTIONS - These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

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: ☐ NO: ☐	If yes, please enter details from your EHIC or PRC below:
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.	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.

Computer Number: _____

NEW PATIENT QUESTIONNAIRE

Welcome to the Crown Medical Centre. To help us provide you with the best possible service, we would be very grateful if you would take the time to answer the following questions. Thank you.

Surname:	Title: Mr/Mrs/Miss/Dr/Other
Forenames:	Previous Surname:
Date of Birth:	NHS Nmb:
Gender:	☐ Man ☐ Woman ☐ Under specialist gender identity clinic
Gender at birth:	☐ Male ☐ Female
Address:	
Postcode:	Home Phone:
Email:	Mobile Phone:
Are you happy to be contacted via SMS (text messaging) for appointment reminders? ☐ Yes ☐ No	

Have you been registered here before? ☐ Yes ☐ No

NEXT OF KIN

Name:	Relationship:
Address (if different from above):	
Telephone Nmb:	

ARE YOU A CARER?

☐ Yes ☐ No	If yes for whom? (e.g. husband/wife/child) _____
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MARITAL STATUS

☐ Single	☐ Separated
☐ Married	☐ Divorced
☐ Living with partner	☐ Widowed

ETHNICITY DATA

White		Black		Asian		Mixed	
White British		Caribbean		Indian		White & Black Caribbean	
Whit Irish		African		Pakistani		White & Black African	
Other white		Other Black		Bangladeshi		White & Black Asian	
				Chinese		Any other mixed background	
				Other Asian			
Other (please specify):							
Please state your first language:							

Computer Number: _____

FAMILY HISTORY

Does anybody in your family have any of the following illnesses? (Please tick and say who)

Condition		Relative	Condition		Relative
High Blood Pressure			Diabetes		
Heart Attack			Asthma		
Angina			Glaucoma		
Stroke (CVA)			Epilepsy		
Cancer – Where?			High Cholesterol		

WOMEN ONLY

How many pregnancies have you had?	
How many children do you have?	
Date of birth(s) of children	
Date of last cervical smear?	
What contraceptive method do you use?	
☐ Pill	☐ Depo
☐ Coil	☐ Implant
Date of replacement (coil & implant only):	

MEDICAL HISTORY

Past Medical History:

Please state any on-going illnesses or disabilities or any significant past illnesses, operations or accident and the years they happened or started.

Current Medication:

Please list medications that you are taking at the present time and the dosage – Please attach a medication list or “right hand side” if you can.

Allergies:

Please state any allergies that you have and the date which they started.

LIFESTYLE INFORMATION

Weight: _____	Height: _____	BMI: _____
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Computer Number: _____

DO YOU EXERCISE AT ALL?

☐ Not at all	☐ Sometimes	☐ Frequently	☐ A lot	☐ Not physically capable
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DO YOU SMOKE?

☐ Never	☐ Current smoker	☐ Ex-smoker	☐ Roll ups	☐ Pipe	☐ Cigars
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If yes, how many a day? _____

ALCOHOL AUDIT

	0	1	2	3	4
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a week
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-8	10+
How often have you have 6 or more units if female or 8 or more units if male, on a single occasion this year	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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
How often during the last year have you failed to do what was normally expected of you, because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you needed an alcoholic drink in the morning, to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
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
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
Have you or somebody been injured as a result of your drinking?	No		Yes but not in the last year		Yes – During the last year
Has a relative or friend, doctor or health worker been concerned about you're drinking or suggest that you cut down?	No		Yes but not in the last year		Yes – During the last year

Scoring:

0 – 7	Lower risk
8 – 15	Increasing risk
16 – 19	Higher risk
20+	Possible Dependence

TOTAL SCORE: _____

Computer Number: _____

VACCINATION HISTORY

Please give us the date of your last vaccinations:

Tetanus vaccination	
Polio vaccination	
Shingles vaccination	
Pneumococcal vaccination	

If you have a copy of your immunisations from your previous GP surgery, please attach them to this questionnaire.