

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
 Signature of Patient Signature on behalf of patient
 Date: / /

**Not all doctors are authorised to dispense medicines*

What is your ethnic group?

Please tick one box that best describes your ethnic group or background from the options below:
White: British Irish Irish Traveller Traveller Gypsy/Romany Polish
 Any other white background (please write in):
Mixed: White and Black Caribbean White and Black African White and Asian
 Any other Mixed background (please write in):
Asian or Asian British: Indian Pakistani Bangladeshi
 Any other Asian background (please write in):
Black or Black British: Caribbean African Somali Nigerian
 Any other Black background (please write in):
Other ethnic group: Chinese Filipino
 Any other ethnic group (please write in):
Not stated:
 Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to.

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

Authorised Signature

Name

Date

____/____/____

Practice Stamp

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 an EU 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 Business Service Authority for the purpose of recovering your NHS costs from your home country.

MEDICAL QUESTIONNAIRE

NAME:

DATE OF BIRTH:

TELEPHONE:

EMAIL:



Montpelier Health

Wellbeing at the heart of the community

OPT IN TO SMS APPOINTMENT REMINDERS? Y|N
 SIGN UP TO ONLINE SERVICES? Y|N
 PREFERRED METHOD OF CONTACT: [PLEASE TICK]
 TELEPHONE EMAIL POST

ETHNICITY [PLEASE TICK AS APPROPRIATE]

| | | | |
|---|--------------------------|--|--------------------------|
| <input type="checkbox"/> WHITE BRITISH | <input type="checkbox"/> | <input type="checkbox"/> INDIAN/BRITISH INDIAN | <input type="checkbox"/> |
| <input type="checkbox"/> WHITE IRISH | <input type="checkbox"/> | <input type="checkbox"/> PAKISTANI/BRITISH PAKISTANI | <input type="checkbox"/> |
| <input type="checkbox"/> OTHER WHITE ETHNIC GROUP | <input type="checkbox"/> | <input type="checkbox"/> BANGLADESHI | <input type="checkbox"/> |
| <input type="checkbox"/> BLACK BRITISH | <input type="checkbox"/> | <input type="checkbox"/> CHINESE | <input type="checkbox"/> |
| <input type="checkbox"/> BLACK CARIBBEAN | <input type="checkbox"/> | <input type="checkbox"/> OTHER ETHNIC MIXED BACKGROUND | <input type="checkbox"/> |
| <input type="checkbox"/> BLACK AFRICAN | <input type="checkbox"/> | <input type="checkbox"/> OTHER [PLEASE SPECIFY] | <input type="checkbox"/> |
| <input type="checkbox"/> BLACK OTHER | <input type="checkbox"/> | | <input type="checkbox"/> |

FIRST SPOKEN LANGUAGE:

SECOND SPOKEN LANGUAGE:

INTERPRETER REQUIRED: DO YOU LIVE ALONE:

DO YOU HAVE ANY PARTICULAR COMMUNICATION NEEDS? [PLEASE STATE] DOES YOUR GENDER AT BIRTH DIFFER FROM YOUR CURRENT GENDER IDENTITY?

CARER STATUS

DO YOU CARE FOR SOMEONE WHO CANNOT MANAGE WITHOUT YOU? Y|N
 [PLEASE GIVE PATIENT DETAILS]

ARE YOU CARED FOR BY SOMEONE? Y|N
 [PLEASE GIVE NAME & CONTACT DETAILS]

TEL:

EMPLOYMENT STATUS [PLEASE TICK AS APPROPRIATE]

IN EMPLOYMENT
 UNEMPLOYED
 STUDENT
 RETIRED
 LONG TERM SICKNESS
 CARER

SMOKING STATUS

CURRENT SMOKER Y|N
 CIGARETTES PER DAY:
 GRAMS PER WEEK:
 VAPE, CIGARS, PIPE Y|N
 EX SMOKER Y|N

HOW MANY UNITS OF ALCOHOL DO YOU DRINK PER WEEK?
 [HALF PINT BEER = 1 UNIT ; ONE GLASS WINE = 1,5 UNITS]

ALLERGIES

PLEASE LIST ANY MEDICATIONS YOU ARE ALLERGIC TO:

PLEASE LIST ANY OTHER SIGNIFICANT ALLERGIES:

HEALTH [PLEASE CIRCLE AS APPROPRIATE]

ISCHAEMIC HEART DISEASE [ANGINA OR PREV. HEART ATTACK] Y|N
 RAISED BLOOD PRESSURE [UNDER CURRENT TREATMENT] Y|N
 HISTORY OF STROKE ; MINI STROKE/TIA Y|N
 DIABETES Y|N
 ASTHMA Y|N

DATE WHEN DIAGNOSED:

MEDICAL QUESTIONNAIRE

CONTINUED

HAVE ANY OF YOUR FAMILY DEVELOPED ANY OF THE FOLLOWING
[PLEASE TICK AS APPROPRIATE]

| FAMILY MEMBER | ANGINA/HEART ATTACK UNDER 60 | DIABETES | STROKE, MINI STROKE OR TIA |
|----------------------|------------------------------|----------|----------------------------|
| MOTHER | | | |
| FATHER | | | |
| SISTER | | | |
| BROTHER | | | |
| PATERNAL GRANDMOTHER | | | |
| PATERNAL GRANDFATHER | | | |
| MATERNAL GRANDMOTHER | | | |
| MATERNAL GRANDFATHER | | | |
| AUNT | | | |
| UNCLE | | | |



Montpelier Health

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PHYSICAL ACTIVITY LEVEL
[TICK AS APPROPRIATE]

HEAVY EXERCISE

MODERATE EXERCISE

LIGHT EXERCISE

INACTIVE

EXERCISE PHYSICALLY IMPOSSIBLE

WE ARE CURRENTLY OFFERING NEW PATIENTS APPOINTMENTS FOR A ROUTINE HIV TEST, IS THIS SOMETHING YOU'D BE INTERESTED IN? Y/N
PLEASE NOTE, IF YES TO THE ABOVE, A RECEPTIONIST WILL BE IN CONTACT WITH YOU ONCE AN APPOINTMENT BECOMES AVAILABLE, POST REGISTRATION.

NEXT OF KIN

PLEASE NOTE, WE CANNOT CONTACT FOREIGN TELEPHONE NUMBERS OR ADDRESSES

NAME:

RELATION:

ADDRESS:

TELEPHONE:

ADDITIONAL TELEPHONE:

PLEASE PROVIDE US WITH YOUR PHARMACY PREFERENCE FOR ELECTRONIC PRESCRIPTIONS SERVICE [EPS]

Full Name.....DOB.....

This brief intervention package is based on the Drink-Less programme originally developed at the University of Sydney as part of a W.H.O. collaborative study.
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UNITS



Pint of Regular Beer/Lager/Cider



Alcopop or Can of Lager



Glass of Wine (175ml)



Single Measure of Spirits



Bottle of Wine

Alcohol Users Disorders Identification Test (AUDIT)

| Questions | Scoring System | | | | | Your Score |
|---|----------------|-------------------|-------------------------------|----------------------|---------------------------|------------|
| | 0 | 1 | 2 | 3 | 4 | |
| How often do you have a drink that contains alcohol? | Never | Monthly or less | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week | |
| How many standard alcoholic drinks do you have on a typical day when you are drinking? | 1 - 2 | 3 - 4 | 5 - 6 | 7 - 9 | 10+ | |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often in the last year have you found you were not able to stop drinking once you had started? | 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 | |
| How often in the last year have you needed an alcoholic drink in the morning to get you going? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| How often in the last year have you had a feeling of guilt or regret after drinking? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily | |
| 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 | |
| Have you or someone else been injured as a result of your drinking? | No | | Yes, but not in the last year | | Yes, during the last year | |
| 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 | |

Scoring: 0-7 = sensible drinking, 8-15 = hazardous drinking, 16-19 = harmful drinking and 20+ = possible dependence