

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 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
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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.

Montpelier Health Centre - Medical Questionnaire - Under 16

Name.....Date of Birth.....

Telephone No.....Mobile No.....

Work No.....Email Address.....

Preferred Method of Contact.....

I would like to OPT IN to the text message appointment reminders Yes/No

I would like to sign up to book appointments online Yes/No

Ethnicity

Please tick your ethnic group below:

White British	<input type="checkbox"/>	Indian	<input type="checkbox"/>
White Irish	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>
Other White Ethnic Group	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>
Black British	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
Black Caribbean	<input type="checkbox"/>	Other ethnic mixed background	<input type="checkbox"/>
Black ARICAN	<input type="checkbox"/>	Other, specity:	<input type="checkbox"/>
BLACK OTHER	<input type="checkbox"/>		

1st spoken language.....2nd spoken language.....

Do you require an Interpreter? Yes/No

If your gender at birth differs from your current gender or gender identity please state

Do you have any particular Communication needs?.....

Allergies

Please name any medication you are allergic to

Please name other significant allergies

Health

Do you have ischaemic heart disease (angina or previous heart attack)? Yes/No

Do you have raised blood pressure that is being treated? Yes/No

Do you have history of stroke or mini stroke/TIA? Yes/No

Do you have diabetes? Yes/No

Do you have asthma? Yes/No

If yes please supply date when diagnosed.....

Montpelier Health Centre - Medical Questionnaire - Under 16

Have any of your family developed any of the following?

	Angina or heart attack under 60	Diabetes	Stroke, mini stroke or TIA
Mother			
Father			
Sister			
Brother			
Grandmother	Maternal	Maternal	Maternal
	Paternal	Paternal	Paternal
Grandfather	Maternal	Maternal	Maternal
	Paternal	Paternal	Paternal
Aunt			
Uncle			

Please Provide us with details of your next of kin:

Name.....Tel/Mob.....

Address.....

Please provide your Pharmacy preference for your prescriptions (This means your prescriptions will be sent electronically to the allocated pharmacy of your choice)

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Montpelier Health Centre
New Patients under 5

We need to know about your child and their medical history so that we can give them the best possible care while they are registered with this practice.

The information you give here will be added to your child’s confidential medical record.

Thank you for helping us.

Child’s name:..... Date of birth: __ / __ / ____

Name of parent/next of kin:.....

Address of parent/next of kin:.....

.....

.

Telephone:.....

Does any other adult not living with the child have responsibility as a parent or guardian? Yes / No

If yes, please give us their details:

Name:

Address:.....

Telephone number:.....

Ethnicity:

Please tick your ethnic group below:

White British		Indian	
White Irish		Pakistani	
Other white ethnic group		Bangladeshi	
Black British		Chinese	
Black Caribbean		Other ethnic mixed background	
Black African		Other, specify:	
Black Other			

New Born Baby Questionnaire

Forenames

Surname

Date of birth

Next of Kin:

Relationship:

Contact Details:

Place of birth:

UK - British

Ethnicity:
(optional)

White White European

Black Caribbean Black African

Asian Please specify

Mixed Please specify