elm house surgery
Beckenham Beacon

ADULT NEW PATIENT REGISTRATION FORM and HEALTH QUESTIONNAIRE

Please complete in BLOCK Capitals

Section A

Mr/ Mrs/ Miss/Ms/ Other…… NHS Number (if known) ……

Surname: …… Forename(s): ……..

Previous surname(s) ……..

Date of Birth: …….. Male ☐ Female ☐

Home Address: ……

…… Postcode: ……..……..

Email: ……..……

Mobile: ……..… Home tel: ……

Town and Country of Birth: ……

Nominated Pharmacy (eg United/Kamsons/TT/Macks/Boots/etc)

Name of Pharmacy:	**Address:**

Occupation: …….. First Language……

What is your Ethnicity (please tick)

White Welsh / English / Scottish / Northern Irish or British ☐ Irish ☐ Gypsy or Irish Traveller ☐ 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 British Asian** Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Any other Asian background (please write in)
Black or Black British Caribbean ☐ African ☐ Any other Black background (please write in)	**Other Ethnic Group** Arab ☐ Any other? (please write in)	**Prefer not to say** ☐

Do you consider yourself to have a disability? Yes ☐ No ☐

If ticked "**Yes**" to the above, please indicate your disability:

Learning disability/difficulty ☐	Long-standing illness ☐	Mental Health Condition ☐	Physical Impairment ☐
Sensory Impairment ☐	Not declared ☐	Other (please state):	

Section B

Please help us trace your previous medical records by providing the following information

Your previous address in UK: ……

…… Postcode: ……..……..

Name and address of previous GP practice: ……

…… Postcode: ……..……..

If you are from abroad: Your first UK address where registered with a GP: ……

…… Postcode: ……..……..

If previously resident in UK: 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 (please tick next to relevant field):			
☐ Regular ☐ Reservist ☐ Veteran ☐ Family Member (Spouse, Civil Partner, Service Child)			
Address before enlisting:		**Postcode:**	
Service or Personnel number:			
Enlistment date:		Discharge date: (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.			

Section C

If you need your doctor to dispense medicines and appliances* (please tick)

☐ 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:	**Date:**
Signature on behalf of the patient:	

***** *Not all doctors are authorised to dispense medicines*

Section D

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

Signature:	**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.

Section E

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

Signature:	**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.

Section F

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:**
Print Name:	**Relationship to Parent:**
On Behalf of:	

Section G

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** ☐ If **yes,** please enter details from your EHIC or PRC below:	**NO** ☐
 *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:**	
	Name:	
	Given Names:	
	Date of Birth (DD MM YYYY):	
	Personal Identification Number:	
	Identification number of the institution:	
	Identification number of the card:	
	Expiry Date (DD MM YYYY):	
PRC validity period (DD MM YYYY):	**(a) from**	**(b)to:**
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. GMS1		

Section H

NEW PATIENT HEALTH QUESTIONNAIRE

SMOKING

Do you smoke? Yes ☐ No ☐

If Yes, how many:

Cigarettes per day …….. Cigars per day ..…... Ounces of tobacco per day ……..

How old were you when you started smoking? ……..

EX-SMOKERS

How old were you when you stopped smoking? ……

How much did you smoke per day? ……..

PASSIVE SMOKING

Are you exposed to smoke at work? Yes ☐ No ☐ At home? Yes ☐ No ☐

ALCOHOL

How many units of alcohol do you drink per week? ……..

(1 unit = half pint of beer, 1 glass of wine, or a pub measure of spirits)

DIET

Do you add salt to your food after cooking?	Yes / No
Do you have a varied diet including milk, meat, vegetables and fruit?	Yes / No
Has your Cholesterol been checked in the last 2 years?	Yes / No

EXERCISE

Do you take regular exercise? Yes ☐ No ☐

If yes, what sort of exercise? ……

How many times per week? ……..

FAMILY HISTORY

Is there any of the following in your family (father, mother, brother, sister) before age of 65?

Heart Disease (heart attacks, angina)	Yes / No	Which family member? ……
Stroke?	Yes / No	Which family member? ……
Cancer?	Yes / No	Which family member? ……
		Site of cancer? ……

MEDICATION

Please give details of any medication which you take (prescribed or otherwise):

Name of drug: ……

Dosage: ……..

Name of drug: ……

Dosage: ……..

Name of drug: ……

Dosage: ……..

ALLERGIES

Are you allergic to any substances or foods? Yes ☐ No ☐

If yes, please give details:

……

……

PAST MEDICAL HISTORY

Please give details of any hospital treatment as an in-patient:

……

Please give details of any treatment for any chronic medical conditions:

……

Please give dates of any X-ray, MRI or CT scans, Mammogram, Ultrasound:

……

IMMUNISATIONS

Dates of Triple/polio/HIB: ……..

Dates of MMR: ..……..

Date of last Tetanus: ……

FEMALE PATIENTS

Date of most recent cervical smear: ……..

Result of most recent smear: …….

CARERS

Do you need / have anyone who looks after you or your daily needs as Carer? Yes ☐ No ☐

If "Yes", would you like them to deal with your health affairs here? Yes ☐ No ☐

(the receptionist can help with these arrangements)

Name: ……. Contact No: …….

Do you care for anyone else? Yes ☐ No ☐

I understand and agree with all the above statements:

Signature:	**Date:**
Signature on behalf of the patient:	**Date:**