

DR J C BINNS  
DR J F KEDWARD  
DR N CHOUDHRY  
DR J MATHEW  
DR T NANDITHA  
DR S JAVED  
DR L JACOB

THE HEALTH CENTRE  
84-86 LONDON ROAD  
BEDFORD MK42 ONT  
Telephone: 01234 266851  
Appointments: 01234 266866  
Fax: 01234 363998

Date: .....

.....

.....

.....

.....

Dear Patient

**Re: Registration at the practice**

You have enquired about registration at this practice, to enable us to proceed with this we have certain checks which we are required to complete for all our patients.

Please find attached a short questionnaire which is given to all patients wishing to join the practice and a list of documentation required for our records. Also attached is a new patient questionnaire, an alcohol screening questionnaire to be completed for all over 16s. Please download the GMS1 form from the website.

All documentation will need to be verified before registration can proceed, by the Home Office if necessary and once his process has been completed we will notify you in writing.

**Yours sincerely**

**For and on behalf of the practice**

Associate GPs: Dr M N Hyder, Dr P Kirubakaran & Dr J Wilson

Practice Manager: Mrs Von Balodis

Eligibility to receive NHS Treatment and to register with the practice is determined by whether a person is ordinarily resident in the UK and is not related to the person's nationality, or payment of national insurance or tax.

Please answer the following questions:

**Do you consider yourself to be a resident of this country?** YES / NO

**Can you prove residency?** YES / NO  
(please see list below for documentation required)

**Can you show that you have the right to live here?** YES / NO

**What is your immigration status?** (Please give the details).....  
(please see list below for documentation required)

**How long have you been settled in the UK?** (Please give the details).....

**Where have you lived for the last 6 months?** (Please give the detail)

.....

**Have you been previously registered with a GP practice within the UK?** YES / NO

(Please give the details) .....

We require the following original documentation to enable us to take copies for verification purposes from all patients wishing to register at the practice:

*Documents to confirm identity:-*

**(Passport plus one other from the list)**

- Birth certificate
- Passport
- Entry clearance documents (Stamped)
- UK Photocard Driving Licence
- Current residence permit (stamped)
- Benefit/pensions book (not card)
- Official tax notification

*The following documents confirm residency:-*

**(One from the list below)**

- Housing contracts
- Utility bills (not mobile 'phone) not over 3 months old
- Bank statements
- Residence Permit
- Official tax (or similar) document
- Work Permit ("Accession countries")

**PATIENT INFORMATION QUESTIONNAIRE**

In line with the governments initiatives we need to make sure the information held in your medical records is as up to date as possible. We would be grateful if you could complete this questionnaire.

Today's Date .....  
 Surname ..... First name(s) .....  
 Full address.....  
 ..... Postcode .....  
 Telephone number (home) ..... (mobile).....  
 Date of birth ..... Male  Female   
 Marital Status ..... Occupation .....  
 Employment status (*please circle*): Full-time; Part-time; Self-employed; Stopped work;  
 Unemployed; Redundant; Unfit for work; Retired;  
 Medically retired; Student

Have you had any serious illness, operations, x-rays or similar tests and when?  
 .....  
 .....  
 .....  
 .....

Have you any allergies to medicines or anything else? .....

**FAMILY HISTORY**

Which of your blood relations have suffered from the following? (please specify)

Heart attack	Cancer	Diabetes	High blood pressure
Asthma	Tuberculosis	Stroke	Glaucoma
High Cholesterol	Other serious illness		

Smoking details (\*please specify amount per day)

Never smoked	Current smoker*	Ex smoker*
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**How much alcohol do you consume per week? (*Please specify amount*)**

Wine..... Beer..... Spirits.....  
 Teetotaller (don't drink).....

**FOR FEMALE PATIENTS ONLY**

Have you had any children? (please specify ages)  
 .....  
 Have you ever had a miscarriage?  
 .....  
 Have you ever had a termination of pregnancy?  
 .....  
 Have you had a hysterectomy?  
 .....  
 Which method of contraception are you using at present?  
 .....

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When was your last smear test?

.....

**VACCINATIONS**

Which vaccinations have you had and when?

Diphtheria	Polio	German Measles	Tetanus
Typhoid	Measles	Cholera	BCG
Yellow Fever	MMR	Whooping Cough	

**What medicines are you taking ?**

Drug name	Strength	No. per day
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

Please tick the appropriate box to indicate your cultural background. These ethnic descriptions are taken from the 2001 census and the answer to this question is totally voluntary.

**A White**

- British
- Irish
- Any other White background, please specify \_\_\_\_\_

**B Mixed**

- White and Black Caribbean
- White and Black African
- White and Asian
- Any other Mixed background, please specify \_\_\_\_\_

**C Asian or Asian British**

- Indian
- Pakistani
- Bangladeshi
- Any other Asian background, please specify \_\_\_\_\_

**D Black or Black British**

- Caribbean
- African
- Any other Black background, please specify \_\_\_\_\_

**E Chinese or other ethnic group**

- Chinese
- Any other, please specify \_\_\_\_\_

Refuse to specify

**Are you an informal carer?**

An informal carer is someone who, without payment provides help and support to a relative, friend or neighbour. Please circle..

Are you an informal carer?    Y    N  
Do you have an informal carer?    Y    N

**NEXT OF KIN DETAILS**

Name..... relationship .....  
Address .....  
Contact no: .....

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Dear Patient

As part of the registration process at this practice we require you to fill in the following information:

Because alcohol use can affect your health and can interfere with certain medications and treatments. It is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or Less	2-4 times a month	2-3 times a week	4 or more times a week
2. 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 to 9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

If you would rather not give this information then please put an X in this box:

Signed: ..... Date: .....

Print Name: .....

Associate GPs: Dr M N Hyder, Dr P Kirubakaran & Dr J Wilson

Practice Manager: Mrs Von Balodis

## 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

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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

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Service or Personnel number	Enlistment date
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## 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 would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate

- Kidneys  
  Heart  
  Liver  
  Corneas  
  Lungs  
  Pancreas  
  Any part of my body

*Signature confirming consent to organ donation*

*Date*

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

### 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: .....

## 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 CHSlist 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.*

Authorised Signature

Name

Date

Practice Stamp