APPLICATION TO JOIN MEDICAL CENTRE

ABOUT YOU (THIS FORM MUST BE COMPLETED BY THE APPLICANT ONLY OR FOR CHILDREN BY PARENT)

Title: First Names:	Surname:	DOB:	Age:

Current Address:..... .... Postcode:.....	Previous Address (moved from):..... .... Postcode:.....
Home Telephone: ..... Mobile Telephone:..... Email Address:..... Occupation:.....	NHS Number:..... Date Of Entry To UK:..... Place Of Birth:..... Ethnicity..... Religion.....

ABOUT YOUR PREVIOUS GP

Previous GP Address **or** state if first GP in UK.....

.....

.....

Postcode:.....

NEXT OF KIN

Name:.....

Relationship:.....

Address:.....

.....

Telephone No:.....

MEDICAL INFORMATION

SMOKING

Smoking Status (please tick): ☐ Non-Smoker

☐ Ex Smoker date stopped?..... ☐ Smoker How many per day?.....

ALCOHOL

Alcohol Consumption: Weekly Consumption in Units (one pint, glass wine, one measure spirits – 2units each) _____units

PREVIOUS MEDICAL HISTORY (ALL past medical problems MUST be declared here or will result in removal)

List ALL previous medical problems/operations/last smear test RESULT for female patients List ALL investigations, diagnosis or treatment that have been done before under any doctor, attach photocopies of previous letters if need be	Date of past episode
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
.....	.....
Are you needing treatment for anything immediately? Yes ☐ No ☐	
.....	.....
.....	.....
.....	.....

MEDICATION (ALL *current & *past medications)

Name of Medication	Dose	How Many Times Per Day?
…….	…….	…….
…….	…….	…….
…….	…….	…….
…….	…….	…….
…….	…….	…….
…….	…….	…….
…….	…….	…….
…….	…….	…….

Allergies (E.g.Penicillin) No □ Yes □,details of allergy……

If current & past medication is not clearly declared it will **NOT** be issued by this health centre.
As per NHS Policy **NO** Branded medicine is prescribed, we prescribe generic medications.

MEDICATION & ADDICTION

Patients who choose to use street/illicit drugs or are addicted to prescribed medication are **NOT** treated at this practice.
If you have used street/illicit drugs the health centre reserves the right to remove your name at anytime from the practice list.

Signature to acknowledge _____ Date_____

APPOINTMENTS

Patients are seen strictly by appointment only. Missing a booked appointment without cancelling will result in removal from the practice list.

Signature to acknowledge _____Date_____

PRACTICE NURSE HEALTH CHECK

On submission of this form you will be given an appointment for a health check with the practice nurse.
Attending this appointment is essential for patients joining the health centre.

No doctor's appointments will be given **before** your health check with the nurse.

Signature to acknowledge_____Date_____

Please bring ALL of your medication and your Childs immunization record/ red book for this appointment.

If a previous medical problem or medication is not declared on this application form, or any false information given, the medical centre reserves the right to remove the patient from its list without notice and at any time.
The same policy applies to all the signed declarations above. Dr S Kumar is the allocated GP for administrative purposes.

COMMUNICATION NEEDS

Do you have any special communication needs (sign language/braille/large-print/interpreter)?_____

HEALTH CENTRE USE ONLY

Form Accepted and Checked By Reception Staff: _____
Proof of ID (Passport/Driving License): Yes ☐ No ☐
Proof of Residence/Address (Utility Bill): Yes ☐ No ☐
Form Reviewed By Partner: _____
Outcome: _____

Patient Practice Number (To be allocated on registration): _____