

## 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

|   |                                   |
|---|-----------------------------------|
| 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

|                             |                 |
|-----------------------------|-----------------|
| Service or Personnel number | Enlistment date |
|-----------------------------|-----------------|

## 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 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     Any part of my body

Signature confirming my agreement to organ/tissue donation    Date \_\_\_\_/\_\_\_\_/\_\_\_\_

*For more information, please ask at reception for an information leaflet or visit the website [www.uktransplant.org.uk](http://www.uktransplant.org.uk), or call 0300 123 23 23.*

### 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: \_\_\_\_\_

HA use only    Patient registered for     GMS     CHS     Dispensing     Rural Practice

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 CHS list 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.*

Practice Stamp

Authorised Signature

Name Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**SUPPLEMENTARY QUESTIONS**

**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.**

|                      |  |                                 |          |
|----------------------|--|---------------------------------|----------|
| <b>Signed:</b>       |  | <b>Date:</b>                    | DD MM YY |
| <b>Print name:</b>   |  | <b>Relationship to patient:</b> |          |
| <b>On behalf of:</b> |  |                                 |          |

**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: <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 The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

# THE MORRIS HOUSE GROUP PRACTICE

## New Patient Registration for Patients under 18 years old

### PLEASE COMPLETE THIS FORM IN BLACK INK

**WHEN APPLYING TO REGISTER, PLEASE BRING IN PHOTOGRAPHIC PROOF OF IDENTITY (e.g. passport, driving licence) AND PROOF OF ADDRESS\* (e.g. utility bills, council tax bill, bank statement; THE DATE SHOULD BE WITHIN THE LAST THREE MONTHS)**

**PLEASE RETURN COMPLETED FORMS BETWEEN 2.30 AND 5.30 P.M. ON MONDAYS, WEDNESDAYS AND FRIDAYS**

### PLEASE COMPLETE ALL SECTIONS

#### Personal Details

|                |
|----------------|
| Surname        |
| First Names    |
| Email address: |

#### Parents' Details

|  |           |               |             |
|--|-----------|---------------|-------------|
| Mother's Details:  | Full Name | Date of Birth | Contact No. |
| Father's Details   | Full Name | Date of Birth | Contact No. |
| Which parent has parental responsibility?      Mother <input type="checkbox"/> Father <input type="checkbox"/> Both <input type="checkbox"/> |           |               |             |
| Address of Person with Parental Responsibility ( <b>ONLY</b> if different from the child's address):   |           |               |             |
| Name of GP Practice mother and father registered if not this practice:   |           |               |             |

#### Details of any Siblings

|            |                |
|------------|----------------|
| Full Name: | Date of Birth: |
| Full Name: | Date of Birth: |
| Full Name: | Date of Birth: |
| Full Name: | Date of Birth: |

What is your first language?

Can you speak English?       Yes       No

Do you have a carer?       Yes       No

|      |             |
|------|-------------|
| Name | Contact No. |
|------|-------------|

Do you care for someone?       Yes       No

|      |             |
|------|-------------|
| Name | Contact No. |
|------|-------------|

Do you have a social worker?       Yes       No

|      |             |
|------|-------------|
| Name | Contact No. |
|------|-------------|

Are you aware of the NHS Summary care Record       Yes       No.      If you are not aware of this, please ask for a leaflet at reception

Are you happy to have a summary care record       Yes       No

#### Medical History

|  |   |  |   |
|--|---|--|---|
| Do you suffer from any of these medical conditions?  | <input type="checkbox"/> Heart disease    | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke                 |
|  | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Asthma/Lung disease    |
|  | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Mental health problems |
| For patients aged 15 and over:   |   |  |   |
| Are you a <input type="checkbox"/> smoker?      How many per day _____ <input type="checkbox"/> ex-smoker?      Date stopped _____ <input type="checkbox"/> Never smoked |   |  |   |
| Are you currently on any REGULAR medication? <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |
| Are you able to administer your own medicine? <input type="checkbox"/> Yes <input type="checkbox"/> No   |   | If not, what is the reason?                  |   |
| If you are taking REGULAR medication AND have had a blood test done within the last six months, please state at which hospital   |   |  |   |

### Specific Needs

|  |  |  |
|--|--|--|
| State any physical or mental disabilities you have (e.g. speech, hearing, sight, etc.)   |  |  |
| State any allergies or sensitivities you have  |  |  |
| <b>Mandatory:</b> Please indicate which chemist you would like us to send your prescriptions to (these will be sent electronically by computer): |  |  |
| <input type="checkbox"/> BeautyChem, 11 Great Cambridge Road   | <input type="checkbox"/> Boots, Wood Green Shopping City | <input type="checkbox"/> Dowsett Pharmacy, Dowsett Road    |
| <input type="checkbox"/> Lloyds, 352 Wood Green High Road  | <input type="checkbox"/> Lords, 439 Lordship Lane        | <input type="checkbox"/> Napclan, 575 Tottenham High Road  |
| <input type="checkbox"/> Napclan, 804 Tottenham High Road  | <input type="checkbox"/> Napclan, 65a White Hart Lane    | <input type="checkbox"/> Phillips, 193 Lordship Lane       |
| <input type="checkbox"/> Porters, 48 Great Cambridge Road  | <input type="checkbox"/> Wise 76a Fore Street            | <input type="checkbox"/> Cross Pharmacy, 471 Lordship Lane |
| <input type="checkbox"/> Other (please state name and postcode)  |  |  |
| Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)? If so, please state name, address, phone number    |  |  |

### Ethnicity

|  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> White British           | <input type="checkbox"/> White Irish            | <input type="checkbox"/> Other mixed background      | <input type="checkbox"/> Moroccan               |
| <input type="checkbox"/> Turkish                 | <input type="checkbox"/> Italian                | <input type="checkbox"/> Indian                      | <input type="checkbox"/> Arab                   |
| <input type="checkbox"/> Polish                  | <input type="checkbox"/> Russian                | <input type="checkbox"/> Caribbean                   | <input type="checkbox"/> White & Asian          |
| <input type="checkbox"/> Croatian                | <input type="checkbox"/> Yugoslavian            | <input type="checkbox"/> African                     | <input type="checkbox"/> Other Black background |
| <input type="checkbox"/> Latin American          | <input type="checkbox"/> Greek Cypriot          | <input type="checkbox"/> Arab                        | <input type="checkbox"/> Bangladeshi            |
| <input type="checkbox"/> Kosovan                 | <input type="checkbox"/> Turkish Cypriot        | <input type="checkbox"/> White & Black African       | <input type="checkbox"/> Chinese                |
| <input type="checkbox"/> Iranian                 | <input type="checkbox"/> Serbian                | <input type="checkbox"/> Other Asian background      | <input type="checkbox"/> Japanese               |
| <input type="checkbox"/> White & Black Caribbean | <input type="checkbox"/> South/Central American | <input type="checkbox"/> Pakistani                   | <input type="checkbox"/> Kurdish                |
| <input type="checkbox"/> North African           | <input type="checkbox"/> Other White            | <input type="checkbox"/> Estonian/Latvian/Lithuanian | <input type="checkbox"/> Bosnian                |
| <input type="checkbox"/> Somali                  | <input type="checkbox"/> Greek                  | <input type="checkbox"/> Albanian                    | <input type="checkbox"/> European               |
| <input type="checkbox"/> Other (please specify)  |   |  |   |

## Alcohol Questionnaire (for patients aged 16 and over)

|  |       |                   |                       |                      |                       |
|--|-------|-------------------|-----------------------|----------------------|-----------------------|
| 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 units of alcohol do you drink on a typical day when you are drinking? ( <b>See unit guidance below.</b> ) | 1 - 2 | 3 - 4             | 5 - 6                 | 7 - 8                | 10+                   |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?     | Never | Less than monthly | Monthly               | Weekly               | Daily or almost daily |



Signature of patient     Signature on behalf of patient \_\_\_\_\_    Date: \_\_\_\_\_

## Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care.

As a new patient at this practice you need to be aware of Summary Care Records. The record will contain information about any medications you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health.

The practice assumes that you are happy for a Summary Care Record to be created for you. However, you can choose not to have a Summary Care Record and can change your mind at any time by informing the practice.

For more information on the NHS Summary Care Records programme, please talk to our practice staff and ask for a leaflet, or visit [www.nhscarerecords.nhs.uk](http://www.nhscarerecords.nhs.uk), or telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

Copies of an opt-out form can be requested from the reception desk, or can be printed from the website [www.nhscarerecords.nhs.uk](http://www.nhscarerecords.nhs.uk) or requested from the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

| FOR OFFICE USE ONLY   |                                  |                                   |  |  |                                  |                               |
|---|----------------------------------|-----------------------------------|--|--|----------------------------------|-------------------------------|
| CHECKED:  | NHS NO. <input type="checkbox"/> | ADDRESS: <input type="checkbox"/> | PT NAME: <input type="checkbox"/>      | IN AREA: <input type="checkbox"/>  | PT DOB: <input type="checkbox"/> | VPP: <input type="checkbox"/> |
| PT REGISTERED WITH US BEFORE <input type="checkbox"/> Yes <input type="checkbox"/> No |                                  |                                   | DATE OF INTRO APPT: ____ / ____ / ____ |  | WITH: GILL / SALLY               |                               |
| RECEPTIONIST NAME:  |                                  |                                   |  | DATE:  |                                  |                               |
| ACCEPTED: <input type="checkbox"/> Yes <input type="checkbox"/> No                    |                                  |                                   |  | <div style="display: flex; justify-content: space-between;"> <span><i>Signature</i></span> <span><i>Date</i></span> </div> |                                  |                               |
| INTRO APPT: <input type="checkbox"/> Yes <input type="checkbox"/> No                  |                                  |                                   |  |  |                                  |                               |

# THE MORRIS HOUSE GROUP PRACTICE

Application for online access to my medical record  
(Please complete in black ink in BLOCK capitals)

**WHEN APPLYING TO REGISTER, PLEASE BRING IN PHOTOGRAPHIC PROOF OF IDENTITY**

|                 |          |
|-----------------|----------|
| Surname*:       | Address: |
| First Name*:    |          |
| Date of Birth*: |          |
| Tel No:         |          |
| Mobile No:      |          |
| Email Address*: |          |

**\*Mandatory fields**

**I wish to have access to the following online services (please tick all that apply)**

|                                   |                          |
|-----------------------------------|--------------------------|
| Booking appointments              | <input type="checkbox"/> |
| Requesting repeat prescriptions   | <input type="checkbox"/> |
| Accessing my brief medical record | <input type="checkbox"/> |

**I wish to access my medical record online and understand and agree with each statement**

|  |
|--|
| I will be responsible for the security of the information that I see or download   |
| If I choose to share my information with anyone else, this is at my own risk   |
| I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement |
| If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible       |
| I agree that the practice may contact me by email in relation to my medical matters  |

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**For Practice use only**

|  |  |                          |
|--|--|--------------------------|
| Identity verified by:  | NHS number:                                  |                          |
| Method:  | Date:  |                          |
| Vouching <input type="checkbox"/>                            | Registration Data Verified - #91B            | <input type="checkbox"/> |
| Vouching with information in record <input type="checkbox"/> | Free text form of ID entered                 | <input type="checkbox"/> |
| Photo ID <input type="checkbox"/>                            |  |                          |
| Authorised by:   | Date account created:                        |                          |
| Date:  | Date pass-phrase sent:                       |                          |
|  | Notes summary verified by clinician - #93440 | <input type="checkbox"/> |