

# Application to Register with a General Medical Practitioner

Please complete in **block capitals** and tick relevant boxes

## Patient details

Surname  Address   
 Forename   
 Previous Surname   
 Date of birth   
 Male  Female   
 I wish the child named above to be registered at the practice for Child Health Surveillance   
 Post code   
 I will be in the area for more than three months   
 Relationship to patient

Patient's / Patient's representative signature \_\_\_\_\_ Date

## Voluntary consent to organ donation

If you wish to register on the NHS Organ Donor Register as someone whose organs can be used for transplantation purposes after your death, please tick relevant box(es) below:

Any Organ  Kidneys  Liver  Lungs  Heart  Corneas  Pancreas   
 Patient's signature \_\_\_\_\_ Date

## Please help us to trace your previous medical records by providing the following information if known

NHS No. (not National Insurance No.)  Community Health Index (CHI) No.   
 Previous address in U.K. \_\_\_\_\_ Name and address of previous doctor in U.K. \_\_\_\_\_  
 \_\_\_\_\_  
 Town \_\_\_\_\_  
 County \_\_\_\_\_ Post code \_\_\_\_\_  
 If returning from abroad \_\_\_\_\_ If returning from HM Forces \_\_\_\_\_  
 Date of departure from U.K.  Date enlisted  Service / Personnel No.   
 Date of return to U.K.

If none of the above information is known then please complete the following:

Town of birth \_\_\_\_\_ Reg. district of birth (see birth certificate) \_\_\_\_\_  
 County of birth \_\_\_\_\_ Mother's maiden name \_\_\_\_\_

## Doctor's agreement

Enter 'D' if supplying drugs   
 CHS acceptance yes  no   
 I accept this patient on my list and I claim payment in accordance with the Regulations.  
 Mileage claim road  water  footpath   
 Enter date if registration examination completed   
 CHS Ref No. of GP providing service if different from below   
 Doctor's signature \_\_\_\_\_ Date  Doctor's name \_\_\_\_\_ GP Ref. No.