

Application to Register with a General Medical Practitioner

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

Patients 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

Relationship to patient I will be in the area for more than three months

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 / Patient's representative 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.

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Town.....

County.....Postcode.....

If never registered in U.K. before Date of 1st entry/...../..... If returning from HM Forces

If returning from abroad Date enlisted/...../.....

Date of departure from U.K. Service / Personnel No/...../.....

Date of return to U.K.

Town of Birth Reg. District of birth (see birth certificate)

County of birth Mother's maiden name

Doctor's agreement

CHS acceptance Yes No CHS Ref No. of GP providing service if different from below

I accept this patient on my list and I claim payment in accordance with the Regulations.

Doctor's signature Date/...../..... Doctor's Name GP Reference Number