

# Application to go on a Doctor's List

Patient's Details

Please complete in BLOCK CAPITALS and tick  as appropriate

Mr  Mrs  Miss  Ms

Date of Birth  /  /

NHS Number (Not NI Number)

Male  Female

Surname

First Name

Middle Names

Previous Surname/s

Town & Country of Birth

Ethnic Origin

Home Address

  
  

Post Code

<input type="text"/>	Tel	<input type="text"/>	Work	<input type="text"/>
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**Please tick if you want to register for Patient Access**

(Patient Access is an on-line service which allows you to book appointments, order repeat prescriptions and view medical records. Further details and access code are available at reception.)

**If you are from the UK**, please help us trace your previous medical records by providing the following information  
Your previous address Name & address of previous Doctor while at that address

<input type="text"/>
<input type="text"/>
<input type="text"/>
Postcode <input type="text"/>

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

**If you are from abroad**

Your first UK address where registered with a GP

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

If previously resident in UK, date of leaving

 /  / 

**If you are returning from the Armed Forces**

Address before enlisting

<input type="text"/>
<input type="text"/>
<input type="text"/>
<input type="text"/>

Service or Personnel Number

Enlistment Date

 /  / 

Your Signature

Date

 /  /

# Office Use Only

**Please complete**

Preferred GP	
New Patient Medical	Yes/No
NPM Date & Time	
Ethnic Form	Yes/No
Main Language Spoken	
I.D. Check	Yes/No
Are you pregnant?	Yes/No    No. of weeks
Parental Responsibility	
Password	
Mother's Maiden Name	
Patient Access - Linkage code issued	
Names of Household Members	

## To be Completed by the Doctor

Your Names

Your Code Number

Your Signature to Accept this Patient

Date