The **Acorn** Group Practice

PLEASE PRINT THESE PAGES

This form is required to register as an NHS patient with the Acorn Group Practice. Please complete the details below in BLOCK CAPITALS and delete as appropriate at the *.
Please return completed forms to Acorn Group Practice, 29-35 Holly Road, Twickenham TW1 4EA.

*Mr/Mrs/Miss/Ms

Surname ……………………………………….

Date of Birth ………………………

First Name ……………………………………….

NHS No……………………………

Previous surname(s)……………………………

*Male/Female

Town & Country of Birth ……………………………….

Home Address ………………………………………………………………………………………...

Postcode …………………………

Telephone No. ……………………………….

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

Your previous address in the UK ………………………………………………………………………

Name of previous doctor while at that address ……………………………………………………….
Address of previous doctor ……………………………………………………………………………..

If you are from abroad

Your first UK address when registered with a GP………………………………………………………
.
If previously resident in UK, date of leaving………………Date you first came to live in the 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, please tick box below

[ ] I wish the child above to be registered with the doctor named below for Child Health Surveillance

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PLEASE SIGN BELOW as *signature of patient or *on behalf of patient

…………………………………………………………… Date ………………………

NHS Organ Donor registration

I would like to join the NHS Organ Register as someone whose organs may be used for transplantation after my death. Please delete as appropriate:
*Kidneys / Heart / Liver / Corneas / Lung / Pancreas / Any part of my body

Signature confirming consent to join organ register ……………………….. Date ………………..

For more information please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk or call 0845 60 60 400

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 only

[ ] 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

[ ] I will dispense medicines / appliances to this patient subject to the Health Authority's approval

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 for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised signature Practice stamp

Name……………………………….. Date ………………

HA use only. Patient registered for [ ] GMS [ ] CHS [ ] Dispensing [ ] Rural Practice

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PATIENT MEDICAL INFORMATION FORM **Date:** ......…………………….................

Please complete the following questions. If necessary, we shall also arrange for your blood pressure to be checked and a specimen of urine to be tested.

Full Name: ....……………….. **Date of Birth:** ....

Email address: ……………………………………………………………..

Do you have any allergies? Please give details : ....

How many cigarettes do you smoke per day? (if none please write none) ….......................................
Please note that if you do smoke we strongly advise you to stop. We would be delighted to give you advice on the range of stop smoking services available in the area.

How many units of alcohol do you drink per week?
(1 unit = one glass of wine, one measure of spirits or half a pint of beer) ....…………… units

Height: .... **Weight:** ....

Have you had or do you currently suffer from any of the following (please tick any that apply)

Angina / heart attack	Diabetes	Thyroid problems
Heart Failure / swollen ankles	Asthma	Cancer
Stroke or 'mini-stroke' (TIA)	Chronic cough / shortness of breath	Depression or any other mental health problems
High blood pressure	Epilepsy	Any operations

Any other health problems? Have you ever been admitted to hospital? ………………………………

……………………………………………………………..……………………………………………………..

Are you taking any regularly prescribed medication?

....……………………………………………………………

Please list any immunisations you have had and the date you had them ………………………………

……

Please tell us about any illnesses in your family (Father, mother, brothers and sisters).

Father: .... **Mother:** ....

Brother(s): .... **Sister(s):** ....

Women patients only: Date and result of last smear test : ....
Please tell us if you are taking the Pill or if you have a coil (intrauterine device) at present:

....

Where did you hear about us? ……………………………………………………………………….
For staff use only: BP:............../………….. smoking & cess advice .... Y/N
Urine: ....………….…...... Registration IOS ....
Pass on for notes summarising? Y / N

ETHNIC BACKGROUND

Research has shown that people with different racial and cultural backgrounds show a different pattern of disease and therefore have different health service needs. The NHS are therefore interested in information regarding Ethnic background.

We would be grateful if you would indicate the Ethnic Group you feel you belong to.

Code	Ethnic group	TICK here
	White	
A	British	
B	Irish	
C	Any other white background	
	Mixed	
D	White and Black Caribbean	
E	White and Black African	
F	White and Asian	
G	Any other mixed background	
	Asian or Asian British	
H	Indian	
J	Pakistani	
K	Bangladeshi	
L	Any other Asian background	
	Black or Black British	
M	Caribbean	
N	African	
P	Any other Black background	
	Other Ethnic Groups	
R	Chinese	
S	Any other ethnic group	

This information will be treated as strictly confidential and will only be available to those specifically involved in your medical care.

ARE YOU A CARER? (Do you care for a disabled adult or child or an elderly person who could not manage to live independently without your help?) **YES / NO**

If "yes" Please tell us who this is: (name)………. …………………………………..

Are they your: Mother / father / daughter / son / niece / nephew / friend /

Other: (please state) ……………………………………………………..

You will be asked to bring in a utility bill when you are registering as proof of your address.
If you are not sure whether you are within our catchment area please check the map on this website or telephone the surgery on 020 8891 0073.

You may be asked to bring in a passport or similar document if you have newly moved to the UK, to show that you are entitled to NHS treatment.

You will be asked to see a doctor or nurse for a new patient check once your registration has been processed. This is to ensure that we are aware of any current health concerns and so forth.

Thank you for your help.