Montpelier Surgery
Under 16's Family Doctor Services Registration GMS1

Please fill out all fields in BLOCK CAPITALS

Title_____ **Surname**_____

Date of Birth | d | d | m | m | y | y | **First Names**_____

Town of Birth_____ **Country of Birth**_____

Current Address

Flat No: (if applicable)_____ House Number_____ Postcode_____

Street Name_____ Telephone_____

Please fill out this section as accurately as possible as we use it to locate your medical records

Your Previous Address

Postcode_____

Name and Address of Previous Doctor

If you are from abroad please give the date you first came to live in the UK. ___/___/__

If Previous Resident in UK date of leaving ___/___/___

Your NHS Number | | | | | | | | | | |

And date returned to live in UK ___/___/__

School Details and Parent/Guardian Details

Parent's Name _____ Telephone Number_____

School Name_____ Address _____

_____

Date Started at School _____/_____/_____

Additional Details

What is your main spoken Language?_____ Would you require an Interpreter? YES/NO

Next of Kin—Please give details of whom to contact on your behalf in an emergency.

Name_____ Relationship to you _____

Contact Number_____ Date of Birth_____

Are you currently taking any medication? If so please specify	
Do you have any allergies? Please give details	

Medical and Family History

Please indicate below if you or a member of your family have suffered from any of the conditions listed below

Condition	You (Date of Diagnosis)	Family (Date of Diagnosis)
Heart Attack / Angina/ Other Chronic Heart Disease		
Heart Failure		
High Blood Pressure requiring medication		
Stroke ( ) Transient Ischaemic Attack ( )		
Diabetes: Type 1 ( ) Type 2 ( )		
Asthma requiring inhalers		
Chronic Obstructive Pulmonary Disease (COPD)		
Epilepsy		
Hypothyroidism		
Chronic Kidney Disease (Please indicate Stage 1-5)		
Depression requiring medication		
Schizophrenia/Bipolar/ other psychoses		
Cancer		
Dementia (Alzheimer's / Parkinson's)		

Patient Signature_____

Signature On Behalf of Patient _____ Name_____

Relationship to Patient_____

Gender	☐ Male ☐ Female ☐Other
Do you now, or have you ever considered your-self Transgender?	☐ Yes ☐ No ☐ I do not wish to disclose this information

I would describe my ethnic origin as		
Asian ☐ Asian British ☐ Bangladeshi ☐ Indian ☐ Pakistani ☐ Any other Asian background **Black** ☐Black British ☐African ☐Caribbean ☐ Sudanese ☐Any other Black background ……	**Mixed** ☐ Asian & White ☐ Asian & Black African ☐ Asian and Black Caribbean ☐ White & Black African ☐ White and Black Caribbean ☐ Any other mixed background …… **White** ☐ British ☐ Irish ☐ Gypsy ☐ Traveller ☐ Polish ☐ Portuguese ☐ Any other White background	**Other Ethnic Group** ☐ Chinese ☐ Turkish ☐ Arab ☐ Japanese Any other ethnic group (please give details) ……... ……... ☐ I do not wish to disclose this

Please indicate your religion or belief		
☐ Agnostic ☐ Atheism ☐ Buddhism ☐ Christianity ☐ Hinduism	☐ Islam ☐ Jainism ☐ Judaism ☐ Pagan ☐ Sikhism	☐ Other ……..... ☐ I have no particular faith I do not wish to disclose this

Do you consider yourself to have a disability or long term limiting condition?	☐ Yes ☐ No ☐ I do not wish to disclose this

Please state the type of impairment which applies to you. People may experience more than one type of impairment, in which case you may indicate more than one. If none of the categories apply, please mark 'other'.

☐ Physical Impairment	☐ Learning Disability / Difficulty
☐ Sensory Impairment	☐ Long-term illness
☐ Mental Health Condition	☐ Other (please state)

……

Are you a carer?	☐ Yes ☐ No ☐ I do not wish to disclose this
If yes do you care for …….?	☐ Parent ☐ Child ☐ Other family member ☐ Partner / spouse ☐ Friend ☐ Other ……..

What age are you?	

For Office Use ONLY **You must see two forms of ID:** **1) Photographic ID** **2) Proof of residency in the Practice Area i.e. proof of address** **Tick below to indicate which you have seen**	
British Passport valid and seen?	
EU Passport valid and seen?	
Other valid Passport seen and photocopied	
Proof of address within catchment area	
Offered New Patient Medical	
Patient informed of registration process	