

Please complete in BLOCK CAPITALS and tick ☒ as appropriate

27/06/2019 15:08

To be completed by the GP Practice

Practice Name

Willow Tree Family Doctors

Practice Code

E84015

☐ I have accepted this patient for general medical services on behalf of the practice

☐ I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Authorised Signature

Name Date ____/____/____

Practice Stamp

Willow Tree Family Doctors

343b Stag Lane

London NW9 9AD

Tel 0208 204 6464

SUPPLEMENTARY QUESTIONS QUESTIONS - These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice. However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK. Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges. More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice. You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment. The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided. Please tick one of the following boxes:



- a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice
- b) ☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested
- c) ☐ I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me. A parent/guardian should complete the form on behalf of a child under 16.

Signed:		Date:	DD MM YY
Print name:		Relationship to patient:	
On behalf of:			

Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS AND S1 FORMS

Do you have a <u>non-UK</u> EHIC or PRC?	YES: <input type="checkbox"/> NO: <input type="checkbox"/>	If yes, please enter details from your EHIC or PRC below:
 <p>If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.</p>	Country Code: 	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	DD MM YYYY
	PRC validity period (a) From:	DD MM YYYY

Please tick ☐ if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). Please give your S1 form to the practice staff.

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process. Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

Now please email this form to the practice : patient.willowtreefamilydoctors@nhs.net

CHIGWELL MEDICAL CENTRE

300 Fencepiece Road, London, IG6 2TA

New Patient Registration – Child/Young Person (0-18yrs)

Date: _____

Surname: _____ Forename: _____ Date of Birth: _____ Gender: _____

Current Address: _____ Post Code: _____

Previous Address: _____ Post Code: _____

NHS Number: _____ Place of Birth: _____ Telephone Number: _____

Registered GP: _____

Ethnic Origin: _____ (Please select from below picking list)

White British / White Irish / Any other White background / Black Caribbean / Black African
Black – other, non mixed origin / Black – other, mixed / Indian / Pakistani / Bangladeshi / Chinese
Other ethnic non mixed (NMO) / Other ethnic, mixed origin / Vietnamese / Other Asian ethnic group

Main language spoken: _____

Lifestyle Questionnaire

Weight: _____ Height: _____

Allergy to Drugs (Please state which): _____

Medical History

Serious Illness: _____ Date _____

_____ Date _____

Accidents _____ Date _____

Operations _____ Date _____

_____ Date _____

Carer/Daytime Details

Primary Carer: _____ Carer's Telephone: _____

Relationship of Carer to child/young person: _____

Name of School: _____ School Telephone Number: _____

Current Medications and Dose

1 _____ 2 _____ 3 _____

4 _____ 5 _____ 6 _____

Family History

Heart Disease Y/N
Diabetes Y/N
Strokes Y/N
Asthma Y/N
Cancer Y/N

Immunizations:

Diphtheria/Tetanus/Pertussis/Polio/Hib/Meningitis

1st Dose (8 weeks) _____

2nd Dose (12 weeks) _____

3rd Dose (16 Weeks) _____

MMR (12 months) _____

Name of Person completing this form: _____
Diphtheria/Tetanus/Pertussis/Polio/MMR (4 ½ years) _____

Diphtheria/Tetanus/ /Polio Booster (15 Years) _____

Signed: _____ Other: BCG _____ Meningitis _____