The Allan Practice
Calcot Medical Centre, Hampden Road, Chalfont St. Peter, Gerrards Cross, Bucks, SL9 9SA
01753 887 311 | registrations.theallanpractice@nhs.net

Registering as a patient at The Allan Practice

We are very pleased that you would like to register as a patient at The Allan Practice. Please complete the attached registration form and Patient Health Questionnaire. If you are registering children, a separate form and questionnaire must be completed for each child. Photographic proof of identity and proof of address (utility bill, council tax bill or bank statement. Mobile phone bills are unacceptable) will be required for each prospective patient.

To register at The Allan Practice, you will need:	
For UK Nationals	**Checklist | Office Use Only**
1) Completed GMS1 Form 2) Valid Photographic ID 3) Proof of Address	
For patients from the EU	**Checklist | Office Use Only**
1) Completed GMS1 Form *This must include the date you moved to the UK 2) Valid Passport or National Identity Card 3) Proof of Address	
For Patients from Non-EU Countries	**Checklist | Office Use Only**
1) Completed GMS1 Form *This must include the date you moved to the UK 2) Valid Passport 3) Valid Visa* 4) Proof of Address *Your Visa details will be noted, and you will have to present valid documents after expiry.	
NB: The possession of an NHS number does not necessarily entitle you to all NHS Services.	**Office Use Only Processed By**
I am aware that processing my application may take up to 7 working days and that I am entitled to urgent, necessary care in the meantime. Patient Name: Date: Patient Signature:	

The Allan Practice

Adult Health Questionnaire (Confidential)

Please print your answers clearly.

Surname			
Forenames			
Address			
Postcode			
Title	Mr / Mrs / Ms / Miss / Master / Dr / Rev / Other:		
Date of Birth		**Gender**	Male / Female
Telephone Numbers			
Home	**Work**	**Mobile**	
E-mail			
I agree to receive communications via text messages or via email	Yes / No		
Marital Status	Single / Married / Separated / Widowed / Divorced / Cohabiting		
Occupation			
Next of Kin			
Relationship to you			
Telephone Numbers			
Home	**Work**	**Mobile**	
Emergency Contact			
Relationship to you			
Telephone Numbers			
Home	**Work**	**Mobile**	
What is your ethnicity?			
British	**Irish**	**African**	**Asian**	**Bangladeshi**
Caribbean	**Chinese**	**Indian/British Indian**	**Pakistani/British Pakistani**	
Other White (please state)		**Other Asian Background (please state)**		
Other Black Background (please state)		**Other Mixed Background (please state)**		
Other (please state)		**Not Stated**		
What language do you speak?				
Do you use an interpreter?	Yes / No			

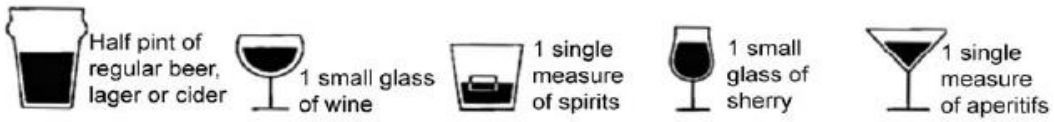
Carers		
Are you a carer? A carer provides unpaid support and care on a regular and substantial basis to a family member, friend or neighbour who would not be able to live independently without them due to frailty, illness or disability.	Y	N
Do you have a carer? If yes, please provide their details:	Y	N
Military Personnel and Veterans		
Have you ever served in the Armed Forces? If yes, please state the length of your service & date of discharge if applicable:	Y	N
Are any of your direct relations a member of the Armed Forces? Please specify:	Y	N
Specific Needs		
Do you have a sensory impairment? Please specify:	Y	N
Do you have any physical disabilities? Please specify:	Y	N
Do you have an Assistance Dog?	Y	N
Do you have any learning or psychological disabilities? Please specify:	Y	N
Do you have a Lasting Power of Attorney? If yes, please provide their details	Y	N
Consent to Access Medical Records This practice holds medical records relating to the treatment and services patients receive. We are asking permission for your records to be looked at by external auditors assessing quality of care. These checks are supported as they help to ensure quality & efficiency of treatment in the NHS. The auditors who carry out these checks are bound by strict rules of confidentiality and your records will only be used for the purpose described.		
I DO NOT consent to auditors looking at my medical records (please tick)		
Summary Care Records Your Summary Care Record will contain information about your medications and allergies. It will be used for emergency care to ensure those caring for you have the information to treat you safely.		
I DO NOT want a Summary Care Record **Signed:** **Date:**		
National Data Opt-Out		
You can choose whether your confidential patient information is used for research and planning. You do not need to do anything if you are happy with how your confidential patient information is used. You can change your choice at any time. For more information or to opt-out, please visit: https://digital.nhs.uk/about-nhs-digital/our-work/keeping-patient-data-safe/how-we-look-after-your-health-and-care-information/your-information-choices/opting-out-of-sharing-your-confidential-patient-information		
If you would like your prescriptions sent electronically to a pharmacy, please provide their name and postcode:		

About You		
Height		
Weight		
Waist Measurement		

Smoking Status	Never Smoked	
	Ex-Smoker	
	Current Smoker	
Smokers, what & how much do you smoke?	Cigarettes	/day
	Cigars	/day
	Pipe or Roll-Ups	Grams/Week

Fast Alcohol Screening Test Questions	Scoring System					Your Score
	0	1	2	3	4	
How often have you had 6 (women)/8 (men) or more drinks on a single occasion in the last year?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a week	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	1-3	4-6	7-9	10+	
How often during the last year have you failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Has a relative, friend, doctor or healthcare professional been concerned about your drinking or suggested that you cut down?	No		Yes - not in the last year		Yes – in the last year	
Score						

This is one unit of alcohol



Each of these is more than one unit

Family History

Is there a family history of any of the following conditions? If yes, please state which family member has the condition.

Condition			Family Member	Condition			Family Member
Epilepsy	Y	N		**Bowel Cancer**	Y	N	
High Blood Pressure	Y	N		**Prostate Cancer**	Y	N	
Heart Disease Under 60	Y	N		**Breast Cancer**	Y	N	
Heart Disease Over 60	Y	N		**Asthma**	Y	N	
Rheumatoid Arthritis	Y	N		**Diabetes**	Y	N	

Medical History

Do you have an allergy to any medicines?	Y	N
Please specify		
Do you have any other allergies, e.g. peanuts, latex, bee stings?	Y	N
Please specify		
Do you take any other medicines or dietary supplements?	Y	N
Please specify		

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Child (0-16) Health Questionnaire (Confidential)

Please print your answers clearly.

Surname			
Forenames			
Address			
Postcode		**Telephone No**	
Date of Birth		**Gender**	Male / Female

Mother's Name			
Tel Nos:	**Home**	**Work**	**Mobile**
Email Address			
Father's Name			
Tel Nos:	**Home**	**Work**	**Mobile**
Email Address			

What is your ethnicity?

British	**Irish**	**African**	**Asian**	**Bangladeshi**
Caribbean	**Chinese**	**Indian/British Indian**	**Pakistani/British Pakistani**	
Other White (please state)		**Other Asian Background (please state)**		
Other Black Background (please state)		**Other Mixed Background (please state)**		
Other (please state)		**Not Stated**		
Which language is the main language spoken at home?				
Is an interpreter needed?				

Medical History

Does your child have an allergy to any medicines?	Y	N
Please specify		
Does your child have any other allergies, e.g. peanuts, latex, bee stings?	Y	N
Please specify		

Immunisations	**Date Given**		
	1st	**2nd**	**3rd**
BCG			
DTAP/IPV/HIB Diptheria, Tetanus, Pertussis / Polio / HIB			
Pneumococcal PCV			
Rotavirus			
Meningitis B			
Meningitis C			
HIB/Men C			
MMR Measles, Mumps, Rubella			
DTAP/IPV Diptheria, Tetanus, Pertussis / Polio			
TD/IPV Tetanus, Diptheria / Polio			
Hepatitis B			
Others			