

* Please see guidance notes on reverse of form BEFORE completing

Have you ever been registered at this practice before Yes

| | | | | | | |
|-----|--|--|---------------------------------------|---------------------------------|-----------------------------|------------------------------|
| 1 | GENDER | MALE <input type="checkbox"/> | | FEMALE <input type="checkbox"/> | | |
| 2 | SURNAME | | | | | |
| 3 | PREVIOUS SURNAME(S) | | | | | |
| 4 | FORENAME & middle names | | | | | |
| 5 | DATE OF BIRTH | date | month | year | | |
| 6 | TITLE | MR <input type="checkbox"/> | MRS <input type="checkbox"/> | MISS <input type="checkbox"/> | MS <input type="checkbox"/> | REV <input type="checkbox"/> |
| 7 | HOUSE NAME (if any) | | | | | |
| 8 | House number & 1st line of address | | | | | |
| 9 | 2nd line of address (area) | | | | | |
| 10 | TOWN | | | | | |
| 11 | COUNTY | | | | | |
| 12 | POST CODE | | | | | |
| 13 | LANDLINE TELEPHONE NUMBER | | | | | |
| 14a | MOBILE NUMBER (*) | | | | | |
| 14b | Email address | | | | | |
| 14c | Ethnicity (Ethnic Origin) | | | | | |
| 15 | NHS NUMBER (National Health Service) | | | | | |
| 16 | MAIN SPOKEN LANGUAGE | | | | | |
| 17 | Nominated Pharmacy Name and address of your local Pharmacy | | | | | |
| 18 | PLACE OF BIRTH | | | | | |
| 19 | PREVIOUS GP | DR | | | | |
| 20 | HEALTH AUTHORITY | | | | | |
| 21 | YOUR PREVIOUS KNOWN ADDRESS Including postcode | POST CODE | | | | |
| 22 | DATE ENTERING UK Immigration Information (papers required) If you are visiting this country, do you have Health/Travel Insurance? | Day | Month | Year | | |
| | | Duration of stay | Months | Years | | |
| | | Visa Expiry date | | | | |
| | | Yes Insurance <input type="checkbox"/> | No Insurance <input type="checkbox"/> | | | |
| 23a | NEXT OF KIN | | | | | |
| 23b | ADDRESS | | | | | |
| 23c | TELEPHONE NUMBER | | | | | |
| 23d | RELATIONSHIP to you | | | | | |
| 24 | Early processing of application needed due to: | | | | | |
| 25 | Signature of patient or guardian If guardian: please state relationship to patient | _____ Date of completing the form: _____ Relationship to patient _____ | | | | |

PLEASE ENSURE YOU HAVE PROVIDED THE CORRECT FORMS OF IDENTIFICATION & VERIFICATION OF ADDRESS. ANY APPLICATIONS RECEIVED INCOMPLETE WILL BE RETURNED & WILL CAUSE FURTHER DELAY IN PROCESSING

FOR OFFICE USE ONLY

| | | | |
|--------------------------|-----------------------------------|---------------------------------|--|
| Application received by | | Date received: | |
| Under 5's – email to | Willenhall.healthvisiting@nhs.net | Letter sent to patient on | |
| Identification submitted | | Verification of address checked | |

| How to complete this form. Please see reference numbers as stated | |
|---|--|
| 1 | Please tick the box to state whether you are male or female |
| 2 | State your present surname (last name) |
| 3 | If you have been married or have changed your name by deed poll – please state your last previous surname |
| 4 | Please state your forename as it appears on your birth certificate or passport. |
| 5 | Enter your full date of birth including the date, month and year |
| 6 | Please enter your title, marital status or position |
| 7 | If your house has a name – enter it here. i.e. Bramble Cottage |
| 8 | Enter the first line of your address including the house number |
| 9 | Enter the area of your address |
| 10 | Enter the town. i.e. Walsall, Willenhall |
| 11 | Enter the county. i.e. West Midlands |
| 12 | Enter your post code |
| 13 | Enter your house telephone number and dialling code. i.e. 01922 or 01902 followed by your number |
| 14 | Enter your mobile /Cell phone number: (*) Patients who submit this information will be registered with our FREE patient appointment reminder system. You can also add a works contact number and an email address. |
| 15 | Enter your NHS number: This is a 10 digit number that contains NO letters. It appears on your medical card. If you do not know your NHS number, please contact your previous GP surgery to obtain it. Applications will NOT be processed without it. This does not apply to patients from overseas. |
| 16 | Enter your first language followed by any other languages that you speak. |
| 17 | Nominated Pharmacy – Nearest or most convenient for collection of electronic prescriptions. |
| 18 | State the town/country that you were born in. |
| 19 | State the name of the last doctor you were registered with |
| 20 | State the town of your last address. i.e. Wolverhampton, Walsall |
| 21 | State the address where you were living before the address on your application form, the post code must be included to enable us to trace your medical records. |
| 22 | Please state the date, as stamped in your passport, the day you entered the country. Please also state the length of time you are legally able to stay. A photocopy of your passport will be needed before processing can take place. If you are only visiting this country, do not complete this form and ask at reception about becoming a temporary resident. All passport details will be checked with the UK Border Agency and will take up to 10 days to process. |
| 23a | Enter your next of kin, the person who should be notified in the event of death, a close relative, spouse or partner. |
| 23b | Enter your next of kin's address, if it is the same as your registering address, please enter "same as above" |
| 23c | Enter a contact telephone number for your next of kin. |
| 23d | Please state the relationship of this person to you i.e. mother, father, sister, brother, friend etc. |
| 24 | Please circle if you suffer from any of the following conditions or state other conditions. Priority in processing your application will be given to patients with long-term illnesses or those on life supporting medications. |
| 25 | Please sign and date this form. If you are completing the form on behalf of an applicant, please first make sure that you have a legal right to do so and please state your relationship to the applicant. |
| What happens now? | |
| <ol style="list-style-type: none"> 1. Complete ALL sections; mark N/A (not applicable) in sections that do not apply. Failure to complete will result in delays in processing. 2. Present completed form and identification/verification papers to receptionist and pick up a copy of our practice booklet. 3. You will be notified by post within 14 days as whether you have been accepted or reasons for not being accepted 4. Please do not fill in this form if you have been previously removed from this practice. This does not apply to patients that have previously moved out of the area. 5. Check if we cover your address in our catchment area (map displayed on waiting room wall). Applicants that are out of our area will not be accepted and should not complete a form. <p>All patient acceptances, when notified by post, will need an appointment to see the Healthcare Assistant for a registration check-up, which is compulsory to becoming registered at this practice. You will not be eligible for our services until this registration process has taken place.</p> | |
| ACCEPTABLE FORMS OF IDENTIFICATION AND ADDRESS VERIFICATION NEEDED FOR ALL APPLICATIONS. *ONLY ONE FROM EACH SECTION IS REQUIRED* (WE WILL PHOTOCOPY FOR FREE) | |
| <p>IDENTIFICATION, a current passport, driving licence, a current EU national identity card, Blue disabled parking permit (photo version only), police warrant card or armed forces ID card, P.A.Y.E coding notice form the inland revenue, benefit letter/Pension letter, this must be for the current tax year.</p> <p>VERIFICATION OF ADDRESS, a current valid driving licence showing your current address (if not already produced as identification), a utility bill dated within the last 3 months, a council tax bill for the current tax year, bank statement valid within the last three months.</p> | |
| <p>Please note: if you have a UK photo card driving licence showing your current address & you were born in the UK, you will only need to supply this for both Identification and address Verification. If under the age of 16 and born in the UK, please provide a birth certificate.</p> | |