

NHS Family doctor services registration

Patient's details	Please complete in BLOCK CAPITALS and tick	
Mr Mrs Miss] Ms Surname	TOTAL VIEW OF THE PARTY OF THE
Date of birth	First names	
NHS No.	Previous surname/s	
☐ Male ☐ Female	Town and country of birth	
Home address		
Postcode	Telephone number	
Please help us trace your r	previous medical records by providing the following	information
Your previous address in UK	Name of previous GP practice while at t	
	Address of previous GP practice	
If you are from abroad		
Your first UK address where registe	ered with a GP	
If previously resident in UK, date of leaving	Date you first came to live in UK	
Address before enlisting:	Reservist Veteran Family Member (Spouse, Civil Partner, Service) Postcode	
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NHS

Family doctor services registration

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☐ I will dispe	nse medicines/applia	ances to this patient subject to	NHS England appr	oval.
I declare to the b	best of my belief this in	nformation is correct	Practic	re Stamp
Authorised Signa	ature			
Name Da	ate			
answers will no	RY QUESTIONS – The ot affect your entitle	ese questions and the patient ement to register or receive se	declaration are opt	tional and your
		TION for all patients who a		
	land can register with	a GP practice and receive free m	edical care from that	practice.
However, if you	are not 'ordinarily resi	dent' in the UK you may have to g lawfully in the UK on a proper	pay for NHS treatme	nt outside of the GP practice. B
of countries outs	side the European Eco	nomic Area must also have the s	tatus of 'indefinite lea	itime being. In most cases, nati ive to remain' in the UK.
Some services, su	uch as diagnostic tests	of suspected infectious diseases	and any treatment of	those diseases are free of charg
		not ordinarily resident here are ce, exemptions and paying for N		
patient leaflet, a	vailable from your GP	practice.		
You may be aske	ed to provide proof of	entitlement in order to receive	ree NHS treatment ou	rtside of the GP practice, other
immediately nec	essary or urgent treati	nt. Even if you have to pay for a ment, regardless of advance pay	ment.	ys be provided with any
The information	you give on this form	will be used to assist in identify	ing your chargeable s	tatus, and may be shared, inclu
		s (e.g. hospitals) and NHS Digita half of the NHS to confirm any o		
	of the following boxes		, , , , , , , , , , , , , , , , , , , ,	
a) I understar	nd that I may need to	pay for NHS treatment outside	of the GP practice	
b) I understa	nd I have a valid exem	ption from paying for NHS tr	eatment outside of th	
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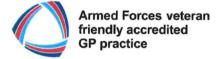


Cressex Health Centre

Hanover House Coronation Road Cressex Business Park High Wycombe Bucks HP12 3PP

t. 01494 415788 f. 01494 526345

Branch Surgery: 43 London Road, High Wycombe HP11 1BP



We would like to welcome you as a new patient to Cressex Health Centre

In order to register at our practice we ask you to provide the following:

- 1. Evidence of ID Passport/Birth Certificate/UK Driving Licence
- 2. Proof of address Utility Bill/Bank statement/Mortgage Agreement (*Or Official letter received at your residence)
- 3. NHS registration form*

Your address must be within our practice boundary which includes most of High Wycombe and a few of the outlying villages south of the M40 corridor. Please speak with reception if you are unsure.

We have two sites. Our main site is Hanover House, Coronation Road, Cressex Business Park, High Wycombe and our branch surgery is Lynton House, 43 London Road, High Wycombe. As a patient of Cressex Health centre you may book appointments at either site.

We offer NHS Health Checks with the nurse/HCA if you are between 40 and 74; please book this in with our reception team.

If you have any queries please do not hesitate to contact our reception desk and they will be happy to help. The number for our surgery is at the top of this letter.

Please note: We will automatically assign one of our salaried GPs to all new patients, this will be selected at random and does not affect the care you will receive. You are entitled to see any GP/Nurse within the practice.

Best Wishes

Cressex Health Care Primary Care Team

**Please ensure that you have completed the name and address of your previous doctor, this will help us locate your previous record and prevent a delay in any care.



NEW UNDER FIVES REGISTRATION AT CRESSEX HEALTH CENTRE

Childs Name	
Date of Birth	
NHS Number	
Main Language	
Ethnicity	
Allergies	
Mothers Name	
Date of Birth	
NHS Number	
Address	Telephone Number:
	Mobile Number:
Previous Address	
Previous GP	Previous Health Centre
Any other family members	
Please provide records of child's previous in	nmunisations

CHILDS IMMUNISATION HISTORY

PLEASE WRITE CLEARLY & IN BLOCK CAPITALS (One form per child)

Childs full name:							
Date of Birth:							
GP Surgery:							
NHS No:							
Routine Childho	Age ι	sually given	Date Given (dd/mm/yy)				
1 st DTaP/IPV/HIB Diphtheria, tetanus, pertussis, polio and Hib							
Hepatitis B							
MEN B		Meningoco	ccal B		2 months		
Rotavirus							
PCV 2 nd DTaP/IPV/HIB Diphther		Pneumoci					
Hepatitis B	ia, tetanus,	pertussis, poli	o and Mib	 ,	3 months		
Rotavirus							
3"d DTaP/IPV/HIB Diphther	ria, tetanus,	pertussis, poli	o and Hib				
Hepatitis B							
Men B Meningococcal B					4 months		
PCV							
Hib / Men C							
1 st MMR Measies, Mumps, Rubella				12.	13 months		
PCV Pneumococcal booster					23 months		
MEN B							
2°d MMR Measles, Mumps, Rubella			_	3 yrs 4 months			
4 th /Pre School Booster DTaP/IPV Diphtheria, tetanus, pertussis, polio			арргох.				
		-					
NON ROUTINE VACCINES	Date given (DD/MM/YY)			c	OTHER VACCINES RECEIVED		
BCG							
Meningitis C							
Hib Booster (Haemophilus Influenza B)					_		
Hepatitis B	1 112	2 nd	3"	4th			
Are you following of No, please state Parents Name:	1948				The state of the s		
Date/							