Dr Alistair Adey
BSc MBBS DRCOG MRCGP

Dr Julia Dancy
MBChB MRCP MRCGP DCH DTM&H DFFP

Dr Edward Argent-Belcher
MA (Cantab) MB BChir MRCGP

Dr Rachel Callely
MBBS MRCP MRCGP

Dr Kathryn Cheong
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RURAL ALLIANCE
NHS Providing NHS services
'Seamless care, working with our community'

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IDENTIFICATION & ETHNIC ORIGIN FORM

When registering with the practice you will need to provide proof of your identity and proof of address when handing in the registration forms. You will need to provide ONE of the documents from EACH of the lists below:

Patient's Name: …….. D.O.B: ……

Address: ……...

PROOF OF IDENTITY

please tick relevant box

- Passport ☐
- Driving Licence ☐
- Birth Certificate ☐
- Marriage Certificate ☐
- Medical Card ☐

PROOF OF ADDRESS

please tick relevant box

- Utility bill ☐
- Bank / Building Society statement ☐
- Payslip (with address) ☐
- External correspondence (Solicitors / Estate Agent) (showing name and address) ☐

PRESCRIPTION NOMINATION (FOR ELECTRONIC PRESCRIPTIONS)

please tick relevant box

Did you have a pharmacy nomination to receive electronic prescriptions at your last practice? Yes ☐ No ☐
If yes, this will be denominated and you can, if you wish, nominate a new pharmacy of your choice

* P.T.O for ethnic origin / main language spoken form.

ETHNIC ORIGIN / MAIN LANGUAGE SPOKEN

Patient's Name: …….. D.O.B: …….

Address: ……...

Please state your ethnic origin by putting a tick in the appropriate box below. This information is optional.

White

White British	☐	
White Irish	☐	
Other White background	☐	please specify _____

Black or Black British

Caribbean	☐	
African	☐	
Other Black background	☐	please specify _____

Asian or Asian British

Indian	☐	
Pakistani	☐	
Bangladesh	☐	
Chinese	☐	
Other Asian background	☐	please specify _____

Mixed

White and Black Caribbean	☐	
White and Black African	☐	
White and Asian	☐	
Other mixed background	☐	please specify _____
Other ethnic background	☐	please specify _____

Not stated ☐ (to be completed by Practice staff if patient ticks none of the above)

MAIN LANGUAGE SPOKEN (tick as appropriate)

English	☐	
Other	☐	please specify _____

If other: please specify if you need an interpreter when communicating with the Practice.

Yes	☐
No	☐

OTHER INFORMATION

Please list any information you think we should be aware of, which could affect your treatment eg allergies, conditions (your medical records may take some weeks to arrive at the practice):

_____

_____