PATIENT APPLICATION TO JOIN SURGERY OR CHANGE OF NAME

New Patient Registration

(one form to be completed for each member of a family)

***** When registering a newborn please include Family Relationship form*****

Name Surname:	First Name:	Other names:			
Have you previously been registered at this practice?		Yes		No	
Date of birth:					
Current Address:	Post Code				
Current Telephone:					
If you have recently moved to the area, your previous address:					
	Post Code				
Name of previous doctor					
Name and address of previous surgery:					
	Post Code				

Form of identification (please tick)	√	Passport, license or cert. number
Birth Certificate		
Valid UK Passport		
Valid non-UK Passport		
Valid UK photo driving license		
Birth Certificate		

Other form of identification and/or confirmation of address (Rental agreement, utility bill, Bank statement, mobile phone contract, DHSS letter, electoral role etc)

PLEASE TURN OVERLEAF FOR CHANGE OF ADDRESS FORM **PTO….**

Change of name / address (one form to be completed for each member of a family)

PLEASE NOTE THAT IF YOU ARE UNDER THE CARE OF THE HOSPITAL YOU WILL NEED TO LET THEM KNOW ABOUT YOUR CHANGE OF ADDRESS.

Surname:	**First Name:**	**Other names:**
	Date of birth:	
	Current Address: **Post Code**	
	Current Telephone:	
New Name (if applicable) **Surname**	**New first name (**if other than just change of surname**)**	
	New address (if applicable) **Post Code**	

Proof of change of name (please tick document provided)		
	√	
Marriage certificate		
Deed Poll letter		
Solicitor's letter		
Adoption certificate		
Other document that shows new name (Please state nature of document)		

Staff member who accepted documentation to sign and date here please.	

Family relationship form

(To be completed for all newborn registrations)

Name of Newborn Surname:	First Name:	Other Names:
Date of birth:		

Name of mother:	Date of Birth:	Address:
Current telephone no:	Are you a patient of the Argyle Medical Group? Yes or No:	Post Code:

Name of father:	Date of Birth:	Address:
Current telephone no:	Are you a patient of the Argyle Medical Group? Yes or No:	Post Code:

Name brothers & sisters:	Date of birth:

Please add below any other contacts who may be involved in the care of your child, if you would like the surgery to hold these details; for instance grandparents or child-minders.	
Name:	Contact telephone number:

Office use only – document to be sent for clinical scanning.

Staff member who accepted documentation to sign and date here please.	