Healthcare
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APPLICATION TO JOIN LIST OF PATIENTS

OF DOCTOR……..

Surname:		Title: (Mr/Mrs/Ms/Master/Miss/ Other)	
Forename(s):		Maiden Name:	
Date of Birth:		Marital Status:	
Address:			
		Post Code:	
Email Address:		Please confirm you will be happy to receive emails: YES/NO	
Telephone:	Home:	Mobile:	Business:
If a minor, name of parent/guardian			
Name of previous doctor:			
Previous doctor's address:			
Patient's previous address if recently moved:			
Do you have medical insurance cover?	Yes/No		
If yes give details:			
Membership No:			
States Health Benefit Card Number:	GY		

I hereby consent to my medical notes being released by my former medical practitioner.

Signed:		Date:	

IMPORTANT INFORMATION FOR ALL NEW PATIENTS AND VISITORS TO THE ISLAND

Please be aware that if you do not possess a GY number (States Medical Benefit) you will NOT be eligible for ANY States benefit and will have to pay for ALL medical treatments at the surgery or hospital. This includes all blood tests, x-rays, consultations etc. Please ask a member of staff for clarification if necessary.