

# Eligibility Form

Please print, complete and return to St Pauls Clinic



General enquiries 01633 266140  
Appointment LINE 220410 (8am-12noon)

**St Paul's Clinic**  
Palmyra Place, Newport NP20 4EJ

- I am a permanent resident in the UK (Wales)
- I am an ordinary resident in the UK (Wales) for a settled purpose (work, study) for at least 6 months.
- I have formally applied for asylum in the UK and my application is still under consideration by the Home Office.
- I am a refugee who has been given leave to remain in the UK
- I am an EEA National (Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Irish Republic, Italy, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, & Switzerland).
- I have an **emergency** problem which requires necessary treatment immediately (e.g. chest pains that may indicate heart attack). This would not include having forgotten medication.
- I am not eligible for NHS treatment and need to be seen as a private patient.\*

\*Charge: £45 for ten minute consultation.  
Please be aware that there will be a charge payable to the chemist for a private prescription and the medication.

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I am applying for registration as a patient at this practice and I declare my eligibility as identified above.

I understand that if my declaration is later found to be false, I may forfeit my right to treatments at this practice and may be liable for the cost of treatment.

Signed: ..... Date: .....

*(If child - Signature of Parent or Guardian)*

# St Paul's Clinic

Palmyra Place, Newport NP20 4EJ



**Section A (To be completed by patient)**

Comp No:

Surname: ..... Forename: .....

Previous Surname: ..... Date of Birth: .....

Current Address: .....

Postcode: ..... Telephone Number: .....

Gender: Male  Female

Marital Status: Single  Married  Widow  Divorce

Separated  Other

Occupation: .....

Do you have a disability? .....

Would you like any assistance on your visit? .....

**Name and Address of your previous General Practitioner:**

Dr: .....

Address: .....

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## MONITORING INFORMATION

Date of Birth	
Gender	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> I do not wish to disclose

## EQUALITY ACT 2010

I would describe my ethnic origin as:

<p><b>Asian or Asian British</b></p> <input type="radio"/> Bangladeshi <input type="radio"/> Indian <input type="radio"/> Pakistani <input type="radio"/> Any other Asian Background	<p><b>Mixed</b></p> <input type="radio"/> White & Asian <input type="radio"/> White & Black African <input type="radio"/> White & Black Caribbean <input type="radio"/> Any other Mixed Background	<p><b>Other Ethnic Group</b></p> <input type="radio"/> Chinese <input type="radio"/> Any other Ethnic Background <input type="radio"/> I do not wish to disclose this information.
<p><b>Black or Black British</b></p> <input type="radio"/> African <input type="radio"/> Caribbean <input type="radio"/> Any other Black Background	<p><b>White</b></p> <input type="radio"/> British <input type="radio"/> Irish <input type="radio"/> Any other White Background	

Please select the option which best describes your sexual orientation:

<input type="radio"/> Lesbian <input type="radio"/> Gay <input type="radio"/> Bisexual	<input type="radio"/> Heterosexual <input type="radio"/> I do not wish to disclose this information
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Please indicate your religion or belief

<input type="radio"/> Atheism <input type="radio"/> Buddhism <input type="radio"/> Christianity <input type="radio"/> Islam	<input type="radio"/> Jainism <input type="radio"/> Sikhism <input type="radio"/> Judaism	<input type="radio"/> Hinduism <input type="radio"/> Other <input type="radio"/> I do not wish to disclose this information
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Do you consider yourself to have a disability?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> I do not wish to disclose this information.
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Please state the type of impairment which applies to you.  
 People may experience more than one type of impairment, in which case you may indicate more than one. If none of the categories apply please mark "Other"

<input type="radio"/> Physical Impairment <input type="radio"/> Sensory Impairment <input type="radio"/> Mental Health Condition	<input type="radio"/> Learning Disability/Difficulty <input type="radio"/> Long-Standing Illness <input type="radio"/> Other
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## Practice Registration Health Questionnaire

Newport Local Health Board recommends that all patients provide proof of eligibility to receive NHS medical services. This includes evidence of residence. The onus is on the patients. Occasionally, ongoing evidence may need to be produced to confirm status of residency.

### EVIDENCE OF RESIDENCE

- Utility Bill
- Rent Book
- Driving Licence
- Bank Statement
- Inland Revenue/  
Benefits Docs
- White Medical Card
- Occupancy  
Agreement
- Birth Certificate
- Marriage Certificate
- Passport

### EVIDENCE OF RIGHT TO RESIDENCE

- Passport
- Student Visa
- Working Permit
- Working Holiday Permit
- ARC Card
- SA1 or SA2 Form
- Ancestral Visa

A dependant may be classified as wife/husband or child up to the age of 16 or in full time education

Ethnic Origin: .....

Patients Signature: .....

Date: .....

**PLEASE BE AWARE THAT YOU MAY BE CONTACTED BY LETTER FROM THE B.S.C. REGARDING YOUR REGISTRATION  
IT IS IMPORTANT THAT YOU RESPOND TO THE LETTER. OR YOU MAY BE DE-REGISTERED**