NHS Family doctor services registration GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ☑ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

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 previous medical records by providing the following information

Your previous address in UK

Name of previous doctor while at that address

Address of previous doctor

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving

Date you first came to live in UK

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

**Not all doctors are authorised to dispense medicines*

☐ I live more than 1 mile in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

☐ **Signature of Patient** ☐ **Signature on behalf of patient** Date_____/_____/_____

NHS Organ Donor registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

☐ Any of my organs and tissue or

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming my agreement to organ/tissue donation **Date** _____/_____/_____

For more information, please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk, or call 0300 123 23 23.

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register **Date** _____/_____/_____

For more information, please ask for the leaflet on joining the NHS Blood Donor Register

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

042017_003 Product Code: **GMS1**

NHS Family doctor services registration

GMS1

To be completed by the doctor

Doctors Name HA Code

☐ I have accepted this patient for general medical services ☐ For the provision of contraceptive services

☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above* HA Code

☐ I am on the HA CHS list and will provide Child Health Surveillance to this patient **or**

☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above* HA Code

☐ I will dispense medicines/appliances to this patient subject to Health Authority's Approval

☐ I am claiming rural practice payment for this patient.
Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name Date _____/_____/_____

Practice Stamp

SUPPLEMENTARY QUESTIONS

PATIENT DECLARATION for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice.

However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

Please tick one of the following boxes:

a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice

b) ☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested

c) ☐ I do not know my chargeable status

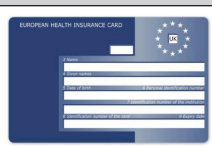
I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		**Date:**	DD MM YY
Print name:		**Relationship to patient:**	
On behalf of:			

Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UK but work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

NON-UK EUROPEAN HEALTH INSURANCE CARD (EHIC), PROVISIONAL REPLACEMENT CERTIFICATE (PRC) DETAILS and S1 FORMS

Do you have a non-UK EHIC or PRC?	**YES:** ☐ **NO:** ☐	If yes, please enter details from your EHIC or PRC below:
	Country Code:	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	DD MM YYYY
PRC validity period (a) From:	DD MM YYYY	(b) To: DD MM YYYY

If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.

Please tick ☐ if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). **Please give your S1 form to the practice staff**.

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

The Junction Health Centre

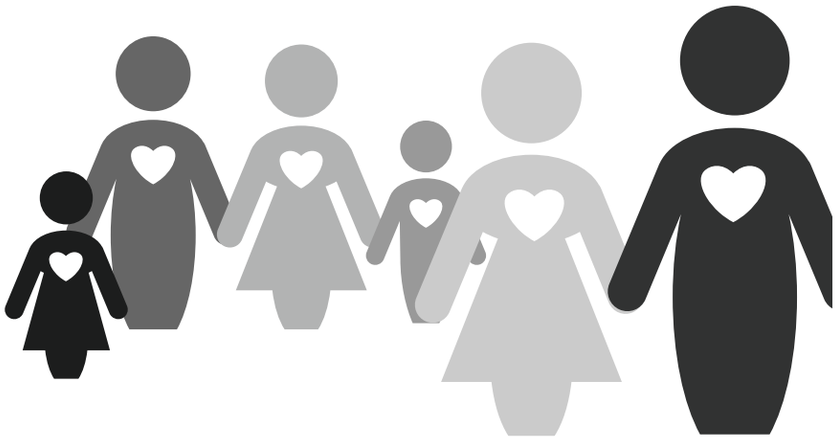
New patient questionnaire

Child 16 years old and under

Children's Registrations (under 16)

Please ensure that you bring the following to a child's registration appointment:

- Birth Certificate
- Red Book
- Any immunisation records·
- Parents proof of address



Please fill out this form in CAPITAL LETTERS

Patient details

First name: _____ **Date of birth:** _____

Surname: _____ **Address:** _____

Gender: ☐ Male ☐ Female _____

Height: (roughly if unknown) _____ **Postcode:** _____

Waist: _____ cm **Mobile number:** _____

Weight: (roughly if unknown) _____ **Home number:** _____

Ethnic origin

☐ White British

☐ White Irish
☐ Other White
☐ Black Caribbean
☐ Black African
☐ Black British

☐ Other Black
☐ Black Caribbean and White
☐ Black African and White

☐ Other Mixed
☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Chinese

☐ Other Asian
☐ Do not wish to state
☐ Other Ethnic Group - please state:

_____

Health overview

How much do you exercise? (for 12 years+)
☐ Light ☐ Moderate ☐ Heavy ☐ Impossible

Which of the following would you describe your diet? ☐ Average ☐ Vegetarian ☐ Vegan

Smoking status?
☐ Never smoked ☐ Ex-smoker
☐ Current smoker - How many per day? _____

Medical history

Does the CHILD suffer with: ☐ Asthma ☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ Epilepsy

Known Allergies: _____

Does ANYONE IN THE FAMILY suffer from:
☐ High Blood Pressure ☐ CVA/ Stroke ☐ Asthma ☐ Heart Disease ☐ Diabetes ☐ Cancer
☐ Epilepsy ☐ Depression ☐ Other - Please state: _____

	DTP – diphtheria, tetanus, pertussis	Polio	Hib	Meningitis C
2 months				
3 months				
4 months				
	MMR		**Hob booster**	
12-18 months				
18 months – 4 years old				
Pre-school Boosters	**DTP**	**Polio booster**	**MMR**	**Single meningitis C**
3-4 years old				
School Boosters	**BCG**	**Tetanus**	**Polio**	**Diphtheria booster**
Others – please state:				

Does the CHILD take any regular medications: _____

_____

Feeding status: ☐ Formula ☐ Breastfed ☐ Formula and breastfed

Parent/next of kin

First name: _____ **Contact number:** _____

Surname: _____ **Relationship:** _____

Language support

What is your first language? _____

Do you speak English? ☐ Yes ☐ No

Do you use any of the following:
Sign Language: ☐ Yes ☐ No
Hearing aid: ☐ Yes ☐ No

Further information

Child's school details - Name of school: _____ Address: _____

_____

Religion

☐ Christian ☐ Jewish ☐ No religion
☐ Buddhist ☐ Muslim ☐ Do not wish to state
☐ Hindu ☐ Sikh ☐ Other – please state:

Protection plan - Is this child subject to a child protection plan? ☐ Yes ☐ No

Foster care information - Is this child in: ☐ Foster care ☐ Private foster ☐ Neither

Do you consider the child to be a disabled person? ☐ No ☐ Yes - please specify

Summary of care records

How we use your data:
A summary care record is an electronic record which contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you have had. Having this information stored in one place makes it easier for healthcare staff to treat you in an emergency, or when your GP practice is closed.

☐ Yes - I give consent for a summary care record to be made
☐ No - I do not wish for a summary care record to be made. Further information on what this means to you can be found at www.nhscarerecords.nhs.uk

Please note: you can change your mind about this at any time by informing the practice

How did you hear about us? ☐ Leaflet ☐ Newspaper ☐ Word of mouth
☐ Internet ☐ Walk-in clinic ☐ Other - specify _____

Methods of contact

The practice may, at times, need to contact you for various reasons. Please inform us of which methods of contact you give consent for:

The practice can leave a message on my voice mail requesting that I make contact with the practice ☐ Yes ☐ No

The practice can leave a message with a third party (eg: family/household member) ☐ Yes ☐ No

The surgery can send a text message (to remind of appointments, health campaigns, updates etc): ☐ Yes ☐ No

The surgery can email with information about the practice, health campaigns, patient newsletters etc: ☐ Yes ☐ No

Please speak to reception if you are interested in the following online services:

- Booking an appointment, ordering prescriptions online and viewing a list of your medication.
- Electronic prescriptions – you can select a nominated pharmacy where your prescription will be sent directly for you to collect. Please speak to reception or a health care professional about signing up.

I confirm I have read and understood all of the above information and give/do not give my consent as indicated in each section.

Signed _____ Print name_____ Date _____

Accessible information standard

Do you have difficulty hearing, or need hearing aids or need to lip-read what people say?

☐ Yes ☐ No

Do you have difficulty with memory or ability to concentrate, learn or understand?

☐ Yes ☐ No

Do you have difficulty speaking or using language to communicate or make your needs known?

☐ Yes ☐ No

Do you have any special communication requirements/require specific communication support?

☐ Sign language ☐ British Sign Language ☐ Makaton sign language ☐ Tadoma sign language

☐ Lip reading ☐ Manual or electronic note taker ☐ Speech to text reporter

☐ Deafblind intervener ☐ Loop system ☐ Other _____

What is the best way to send you information?

☐ Telephone ☐ Text Relay ☐ SMS ☐ Letter ☐ Email ☐ Other _____

Do you need a format other than standard print?

☐ Braille ☐ Easy Read ☐ Large print (at least 20 point font)

☐ Electronic audio format (MP3 or disk) ☐ Other _____

Do you need an advocate? (Someone would will support you to communicate or to express your point of view)

☐ Yes ☐ No

For office use only - additional notes