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

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:
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.	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

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 MORRIS HOUSE GROUP PRACTICE

New Patient Registration for patients aged 18 years and over

PLEASE COMPLETE THIS FORM IN BLACK INK

WHEN APPLYING TO REGISTER, PLEASE BRING IN PHOTOGRAPHIC PROOF OF IDENTITY (e.g. passport, driving licence) AND PROOF OF ADDRESS* (e.g. utility bills, council tax bill, bank statement; THE DATE SHOULD BE WHITHIN THE LAST THREE MONTHS)

PLEASE RETURN COMPLETED FORMS BETWEEN 2.30 AND 5.30 P.M. ON MONDAYS, WEDNESDAYS AND FRIDAYS

PLEASE COMPLETE ALL SECTIONS

Personal Details

Surname:
First Names:

Next of Kin:	Name	Contact No.	Relationship

What is your first language?		Can you speak English? ☐ Yes ☐ No

Question		Name	Contact No.
Do you have a carer?	☐ Yes ☐ No		
Do you care for someone?	☐ Yes ☐ No		
Do you have a social worker?	☐ Yes ☐ No		

Are you aware of the NHS Summary care Record ☐ Yes ☐ No. If you are not aware of this, please ask for a leaflet at reception

Are you happy to have a summary care record ☐ Yes ☐ No

Medical History

Do you suffer from any of these medical conditions?	☐ Heart disease	☐ High blood pressure	☐ Stroke
	☐ Diabetes	☐ Cancer	☐ Asthma/Lung disease
	☐ Thyroid problems	☐ Epilepsy	☐Mental health problems

For patients aged 15 and over:

Are you a ☐ smoker? How many per day ________ ☐ ex-smoker? Date stopped ________ ☐ Never smoked

Are you currently on any REGULAR medication? ☐ Yes ☐ No

Are you able to administer your own medicine? ☐ Yes ☐ No | If not, what is the reason?

If you are taking REGULAR medication AND have had a blood test done within the last six months, please state at which hospital

Specific Needs

State any physical or mental disabilities you have (e.g. speech, hearing, sight, etc.)	
State any allergies or sensitivities you have	

Mandatory: Please indicate which chemist you would like us to send your prescriptions to (these will be sent electronically by computer):

☐ BeautyChem, 11 Great Cambridge Road	☐ Boots, Wood Green Shopping City	☐ Dowsett Pharmacy, Dowsett Road
☐ Lloyds, 352 Wood Green High Road	☐ Lords, 439 Lordship Lane	☐ Napclan, 575 Tottenham High Road
☐ Napclan, 804 Tottenham High Road	☐ Napclan, 65a White Hart Lane	☐ Phillips, 193 Lordship Lane
☐ Porters, 48 Great Cambridge Road	☐ Wise 76a Fore Street	☐ Cross Pharmacy, 471 Lordship Lane

☐ Other (*please state name and postcode*)

Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)? If so, please state name, address, phone number

Ethnicity

☐ White British	☐ White Irish	☐ Other mixed background	☐ Moroccan
☐ Turkish	☐ Italian	☐ Indian	☐ Arab
☐ Polish	☐ Russian	☐ Caribbean	☐ White & Asian
☐ Croatian	☐ Yugoslavian	☐ African	☐ Other Black background
☐ Latin American	☐ Greek Cypriot	☐ Arab	☐ Bangladeshi
☐ Kosovan	☐ Turkish Cypriot	☐ White & Black African	☐ Chinese
☐ Iranian	☐ Serbian	☐ Other Asian background	☐ Japanese
☐ White & Black Caribbean	☐ South/Central American	☐ Pakistani	☐ Kurdish
☐ North African	☐ Other White	☐ Estonian/Latvian/Lithuanian	☐ Bosnian
☐ Somali	☐ Greek	☐ Albanian	☐ European
☐ Other (please specify)			

Please list any other family members who are already patients at this Practice and who live at the same address as you

1.	5.
2.	6.
3.	7.
4.	8.

Alcohol Questionnaire (for patients aged 16 and over)

How often do you have a drink that contains alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week
How many units of alcohol do you drink on a typical day when you are drinking? (***See unit guidance below***.)	1 - 2	3 - 4	5 - 6	7 - 8	10+
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

I UNIT ½ pint 4% beer, lager or cider

I UNIT 1 small glass of wine 9%

I UNIT 1 single 25ml measure of spirits (40%)

I UNIT 1 small 50ml glass of sherry (17.5-20%)

2 UNITS A pint of "regular" beer, lager or cider (4%)

3 UNITS A pint of "premium" beer, lager or cider (5%)

1.5 UNITS Alcopop (5%) or a 275ml bottle of regular lager (4%)

2 UNITS 440ml can of "regular" lager or cider (4%)

4 UNITS 440ml can of "super strength" lager (9%)

2 UNITS 175ml glass of wine (12
3 UNITS 250ml glass of wine (12
9-10 UNITS bottle of wine (12%

☐ Signature of patient ☐ Signature on behalf of patient ____________________ Date: ______________

Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care.

As a new patient at this practice you need to be aware of Summary Care Records. The record will contain information about any medications you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health.

The practice assumes that you are happy for a Summary Care Record to be created for you. However, you can choose not to have a Summary Care Record and can change your mind at any time by informing the practice.

For more information on the NHS Summary Care Records programme, please talk to our practice staff and ask for a leaflet, or visit **www.nhscarerecords.nhs.uk,** or telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

Copies of an opt-out form can be requested from the reception desk, or can be printed from the website **www.nhscarerecords.nhs.uk** or requested from the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

FOR OFFICE USE ONLY						
CHECKED:	NHS NO. ☐	ADDRESS: ☐	PT NAME: ☐	IN AREA: ☐	PT DOB: ☐	VPP: ☐
PT REGISTERED WITH US BEFORE ☐ Yes ☐ No			DATE OF INTRO APPT: _____ / _____ / _____		WITH: GILL / SALLY	
RECEPTIONIST NAME:			DATE:			

ACCEPTED: ☐ Yes ☐ No	
INTRO APPT: ☐ Yes ☐ No	*Signature* *Date*

THE MORRIS HOUSE GROUP PRACTICE

Application for online access to my medical record
(Please complete in black ink in BLOCK capitals)
WHEN APPLYING TO REGISTER, PLEASE BRING IN PHOTOGRAPHIC PROOF OF IDENTITY

Surname*:	Address:
First Name*:	
Date of Birth*:	
Tel No:	
Mobile No:	
Email Address*:	

***Mandatory fields**
I wish to have access to the following online services (*please tick all that apply*)

Booking appointments	☐
Requesting repeat prescriptions	☐
Accessing my brief medical record	☐

I wish to access my medical record online and understand and agree with each statement

I will be responsible for the security of the information that I see or download
If I choose to share my information with anyone else, this is at my own risk
I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible
I agree that the practice may contact me by email in relation to my medical matters

Signature: ______________________________ Date: ____________________

For Practice use only

Identity verified by:		NHS number:	
Method:		Date:	
Vouching	☐	Registration Data Verified - #91B	☐
Vouching with information in record	☐	Free text form of ID entered	☐
Photo ID	☐		

Authorised by:	Date account created:	
Date:	Date pass-phrase sent:	
	Notes summary verified by clinician - #93440	☐