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 GP practice while at that address

Address of previous GP practice

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

Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: ☐ Regular ☐ Reservist ☐ Veteran ☐ Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting:

Postcode

Service or Personnel number: Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

**Not all doctors are authorised to dispense medicines*

☐ I live more than 1.6km 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_____/_____/_____

What is your ethnic group?

Please tick one box that best describes your ethnic group or background from the options below:

White: ☐ British ☐ Irish ☐ Irish Traveller ☐ Traveller ☐ Gypsy/Romany ☐ Polish
☐ Any other white background (please write in):

Mixed: ☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian
☐ Any other Mixed background (please write in):

Asian or Asian British: ☐ Indian ☐ Pakistani ☐ Bangladeshi
☐ Any other Asian background (please write in):

Black or Black British: ☐ Caribbean ☐ African ☐ Somali ☐ Nigerian
☐ Any other Black background (please write in):

Other ethnic group: ☐ Chinese ☐ Filipino
☐ Any other ethnic group (please write in):

Not stated: ☐
Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to.

NHS England use only Patient registered for ☐ GMS ☐ Dispensing

062021_006 Product Code: **GMS1**

NHS Family doctor services registration

GMS1

To be completed by the GP Practice

Practice Name

Practice Code

☐ I have accepted this patient for general medical services on behalf of the practice

☐ I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Practice Stamp

Authorised Signature

Name Date _____/_____/_____

SUPPLEMENTARY QUESTIONS – These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

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 an EU 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 Business Service Authority for the purpose of recovering your NHS costs from your home country.

Patient Health Questionnaire

Dear Patient,
Thank you for registering with Bridge Street Surgery. As we are unsure when your medical records will arrive at this practice; we would be grateful if you could answer the following questions. This will give us a better idea about your health, and help us to look after you.

Date of registration: …….

Personal Details
First name: …… Surname/s ……
Date of birth: ……. Sex: male [ ] female [ ]
Address: ……
…… …… Post code: ……
Telephone number: ……..Mobile Number: ……
Occupation: …… Email ……
Country of origin: …… Ethnic origin: …… (see ethnicity table)
Next of kin (Name): ……Relationship: ……
Next of kin telephone number: ……

Accessible Information:

Do you need help with mobility/hearing/speaking? (Please state what extra help you will need)
[ ] Yes [ ] no

……

Do you require an interpreter? Yes [ ] No [ ] If yes, which language?: ……

Medical History

Do you suffer or have suffered from any of the following conditions, if yes since when?

Heart Disease	Yes [ ] No [ ]	Since:
Stroke	Yes [ ] No [ ]	Since:
Cancer	Yes [ ] No [ ]	Since:
Diabetes	Yes [ ] No [ ]	Since:
Asthma	Yes [ ] No [ ]	Since:
High blood pressure	Yes [ ] No [ ]	Since:
Epilepsy	Yes [ ] No [ ]	Since:
High Cholesterol	Yes [ ] No [ ]	Since:

Please list any other serious **illness, operations or accidents** you had in the past (give dates when possible).
……
……
……
……

Please list any **medicines/tablets** you are currently taking

……

……

……

Do you have any **allergies**? …….Yes [ ] No [ ]

Please list.....

……

Lifestyle

Smoking status

Never smoked: [ ] Ex-smoker: [ ] Current Smoker: [ ] Interested in stopping { }

If current smoker: year when you started: ……. Average cigarettes per day: ……

If ex-smoker: Year when you stopped: ……. Average cigarettes per day: ……..

What regular exercise do you take?

……

……

Family Medical History

Has a member of your immediate family (father, mother, siblings, and grandparents) had or suffered from any of the following? If 'Yes', Please state relationship and condition.

		Relationship
Heart attack	Yes [ ] No [ ]	
Stroke	Yes [ ] No [ ]	
Cancer	Yes [ ] No [ ]	
Diabetes	Yes [ ] No [ ]	
High blood pressure	Yes [ ] No [ ]	
Other	Yes [ ] No [ ]	

Carers

Do you care for a vulnerable person (adult or child) Yes [ ] No [ ]

Contact number.....

Alcohol Screening Questionnaire

Do you drink alcohol? Yes [ ] No [ ]

How many units a week? .....

(Wine: 125ml glass = 1.5 units, 175ml glass = 2.0 units; 250ml glass = 3units, pint of lower strength lager/beer/cider = 2 units; pint of higher strength lager/beer/cider = 3 units; single small shot of spirit = 1 1unit)

Please tick the most relevant box for each question.

Alcohol Screening Questions	Score 0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-3 Times a month	2-3 Times a Week	4 Or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3-4	5-6	7-8	10 or more
3. How often during the last year have you found that you were not able to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you failed to do what was normally expected of you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Has a relative of friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the past year		Yes during the last year

If the total score is five or above it might be useful to discuss alcohol consumption further.

If you would like further information or have any questions around alcohol use please ask to speak to a Doctor or Nurse. If you would like to calculate how many units of alcohol you have per week please go to http://units.nhs.uk

All Patients

Patient records are held on computer as well as paper. GP's are responsible for the confidentiality of these records. On occasions, we share information from the patient records with the local Health Authority, Hospitals and other NHS/Partner organisations in the interests of patient care.

I agree to my records being held under the above terms and I certify that the information I have provided is correct to the best of my knowledge.

Name: ……..

Signature: ……

Date: ……..

BRIDGE STREET SURGERY

Sharing your medical information

Your choices

Health professionals are trained to keep your records secure and to manage them responsibly and in confidence.

There are several models for sharing data which have all been put into place nationally and locally in different years. Please see the Data Sharing Table which shows what information is shared and links below for more information.

Summary Care Records: www.nhscarerecords.nhs.uk and http://systems.hscic.gov.uk

Care Data: www.nhs.uk/caredata

Sharing your record benefits you because:

- You won't need to repeat your medical history
- You avoid unnecessary appointments and tests
- Your health professional has the right information at the right time.

Patients have rights to dissent from sharing their data with other organisations.

Please circle your options and sign below to confirm:

Summary Care Record:	I do not consent	I consent
Care Data:	I do not consent	I consent
Emis Enhanced Sharing Data Model:	I do not consent	I consent

Full name: ……..

DOB: ……

Signature: …….

Signed on behalf: ……..

Date: ……..

BRIDGE STREET SURGERY
ONLINE ACCESS APPLICATION FORM

Patient to complete:

Full Name	
D.O.B.	
Address	
Tel Number	
Email Address	
Practice Guidance read and understood:	Yes/No

Patients signature ……

Date: ……

Surgery use only:

Proof of ID given, e.g. Passport, Driving licence, membership card	Yes/No
Identify confirmed:	Yes/No

Patient Health Questionnaire

Dear Patient,
Thank you for registering with Bridge Street Surgery. As we are unsure when your medical records will arrive at this practice; we would be grateful if you could answer the following questions. This will give us a better idea about your health, and help us to look after you.

Date of registration: …….

Personal Details
First name: …… Surname/s ……
Date of birth: ……. Sex: male [ ] female [ ]
Address: ……
…… …… Post code: ……
Telephone number: ……..Mobile Number: ……
Occupation: …… Email ……
Country of origin: …… Ethnic origin: …… (see ethnicity table)
Next of kin (Name): ……Relationship: ……
Next of kin telephone number: ……

Accessible Information:

Do you need help with mobility/hearing/speaking? (Please state what extra help you will need)
[ ] Yes [ ] no

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High blood pressure	Yes [ ] No [ ]	Since:
Epilepsy	Yes [ ] No [ ]	Since:
High Cholesterol	Yes [ ] No [ ]	Since:

Please list any other serious **illness, operations or accidents** you had in the past (give dates when possible).
……
……
……
……

Please list any **medicines/tablets** you are currently taking

……

……

……

Do you have any **allergies**? …….Yes [ ] No [ ]

Please list.....

……

Lifestyle

Smoking status

Never smoked: [ ] Ex-smoker: [ ] Current Smoker: [ ] Interested in stopping { }

If current smoker: year when you started: ……. Average cigarettes per day: ……

If ex-smoker: Year when you stopped: ……. Average cigarettes per day: ……..

What regular exercise do you take?

……

……

Family Medical History

Has a member of your immediate family (father, mother, siblings, and grandparents) had or suffered from any of the following? If 'Yes', Please state relationship and condition.

		Relationship
Heart attack	Yes [ ] No [ ]	
Stroke	Yes [ ] No [ ]	
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Date: ……..

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Full name: ……..

DOB: ……

Signature: …….

Signed on behalf: ……..

Date: ……..

BRIDGE STREET SURGERY
ONLINE ACCESS APPLICATION FORM

Patient to complete:

Full Name	
D.O.B.	
Address	
Tel Number	
Email Address	
Practice Guidance read and understood:	Yes/No

Patients signature ……

Date: ……

Surgery use only:

Proof of ID given, e.g. Passport, Driving licence, membership card	Yes/No
Identify confirmed:	Yes/No