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*

☐ 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

**Not all doctors are authorised to dispense medicines*

☐ **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

Signature confirming my consent to join the NHS Organ Donor Register **Date** ____/____/____

Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit www.organdonation.nhs.uk or call 0300 123 23 23 to register your decision.

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 my consent to join the NHS Blood Donor Register **Date** ____/____/____

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

Postcode:

All blood types are needed, especially O negative and B negative. Visit www.blood.co.uk or call 0300 123 23 23.

NHS England use only Patient registered for ☐ GMS ☐ Dispensing

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

Authorised Signature

Name Date ______/______/______

Practice Stamp

SUPPLEMENTARY QUESTIONS 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

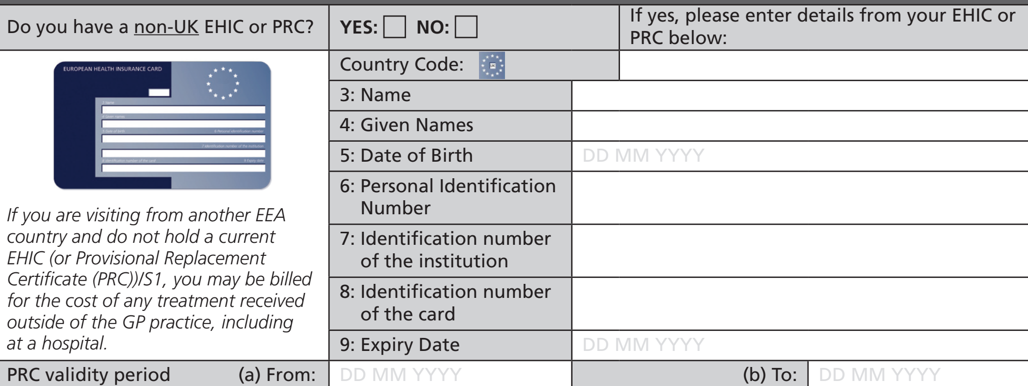
I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

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 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	
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.	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.

Millway Medical Practice FAMILY DOCTOR REGISTRATION SERVICES UNDER 16 YEARS OLD

Dear Parent/Guardian

By answering the questions on this form you will be helping us to deliver better services to your child. It is hoped that this will give us a better picture of the local population, which will help in planning new services and changing existing ones.

We encourage all patients to complete this form on behalf of your child. The information you provide will be treated in the strictest confidence. Information you give will be treated in the same way as other information we hold within the health service and will not breech the Data Protection Act 2003. As has always been the case, no names or other identifying details are released from the practice when information is used for health service planning.

If you need any help to fill in this form, or have any queries regarding this form, please feel free to ask the reception team.

1. Thank you for your help.

Master □ Miss □ Other □

Surname ____ DOB_____/____/______

First Name(s) ____

Previous Surname_______________________________________ NHS Number ________________________

Male □ Female □

Home Address

____

____

Telephone Number: 020 __________________________ Mobile Number _______________________

E-mail Address *(this will only be used for surgery correspondence)*

____

Please help us to trace your previous medical records by providing the following information;

Place of Birth

____

Previous Address in the UK

____

____

Name and Address of your previous doctor

____

____

If you are from abroad

Your first UK address where registered with a GP

____

____

Date you entered the UK ____

Family Details

Mother's Name	
Father's Name	

Brothers, Sisters or other children's details living in your home

Surname	First Name	Date Of Birth

Name, Address & Telephone Numbers

Child Minder

Nursery

School

Child Examinations

6 Week Examination	Date:
7-9 Month Examination	Date:
2 Year Examination	Date:
3 ½ Year Examination	Date:

Immunisations

BCG (Usually given before child's 1st birthday)	Date:
Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type b, Pneumococcal, Rotavirus (2 months old)	Date:
Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type b, Meningococcal C Rotavirus (3 months old)	Date:

Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type b, Pneumococcal (4 months old)	Date:
Hib/Men C Pneumococcal Measles, Mumps, Rubella (12 months old)	Date:
Measles, Mumps, Rubella (15 months old)	Date:
Diphtheria, Tetanus, Pertussis, Polio, (3years 4 months or soon after)	Date:
Human Papillomavirus (girls only aged 12 – 13yrs)	1st Jab Date: 2nd Jab Date: 3rd Jab Date:
Diphtheria, Tetanus, Polio, Meningococcal C (13-18 years old)	Date:
Influenza Nasal Drops/Vaccination	Date:

If there are any other vaccines your child has had that are not listed above please use the space below to provide the details of the jab, name and date they were given.

Has your child had any serious illnesses or operations in the past, if so please give details in this space.

Does your child have any current medical conditions?

Name of condition	Current treatment / Medication?

Does your child have any allergies?

Medication	Food	Anything Else

Smoking

If your child is over the age of 15 please can you tell us if they smoke?

Smoker: Yes ☐ No ☐

If yes how many?

Ethnic Status & Nationality

What is your child's country of birth?

What is your child's main spoken language?

What language does your child prefer to read?

Please tell us your child's ethnic group by ticking the box

White British ☐
White Irish ☐
Gypsy or Irish Traveller ☐
White Other ☐

Black or Black British ☐
Black African ☐
Black Caribbean ☐
Black other ☐

White & Asian ☐
White & Black African ☐
White & Black Caribbean ☐

Asian or Asian British ☐
Bangladeshi ☐
Indian ☐
Pakistani ☐
Arab ☐
Asian other ☐
Chinese ☐

Any other ethnic backgrounds please write. ______________________________

SIGNATURE ON BEHALF OF CHILD: ______________________________DATE____________

Are you, please circle one of the following: Child's parent Foster Parent Guardian

Thank you for taking time to complete this.

Please ask at reception for a practice leaflet to explain the services we offer

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STAFF ONLY

PATIENT'S EMIS NUMBER:

HEIGHT WEIGHT BMI

BP READING /

NP INFORMATION ENTERED ON SCREEN BY:______________________________

REGISTRATION FORM ENTERED ON SCREEN BY:______________________________

DATE ENTERED ON SCREEN______________________________