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: Discharge date: (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

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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 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

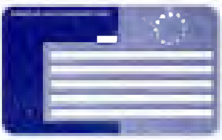
I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

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

Signed:		**Date:**	
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	
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	
PRC validity period (a) From:		(b) To:

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.

For Office Use Only:

Date Received:
Received by:
Proof Seen:

Registered by:
Date Registered:

Adult New Patient Registration Form

Please give quite detailed information about yourself to enable us to provide the best care for you. All information will be kept strictly confidential. Please ask for a separate sheet if needed.

PLEASE ANSWER ALL THE QUESTIONS OR YOUR REGISTRATION MAY BE REJECTED OR DELAYED.

Please complete this form in BLOCK CAPITALS and tick the boxes as appropriate

About Yourself:

Title	MR/ MRS/ MS/ MISS/ DR/ OTHER	**Date of Birth**	
First Name		**Surname**	
Address		**Post Code**	
Home Telephone		**Mobile**	
Email Address	**Please write clearly:**		
Country of Birth		**Ethnicity**	

Communication Needs

Main Language	
Interpreter: Spoken language or sign language interpreters are available upon request	**Do you Require an Interpreter?** (please tick YES or NO) **NO [ ]** **YES [ ]** **Detail:** ______________________
Preferred Contact Method	Please choose ONLY one: **Text (SMS) [ ]** **Email [ ]** **Letter [ ]**

Next of Kin

(who you would like us to contact in an emergency):

Name of next of kin:	
Relationship to patient:	

Telephone (s) number of next of Kin:	**Home:** **Mobile:**

Carers

A carer is anyone, including children and adults who looks after a family member, partner or friend who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without their support.

Are You a Carer?	**NO [ ] YES [ ]** **If YES, Who do you care for:** ______________________
Do you have a Carer?	**NO [ ] YES [ ]** **If YES, Who is your carer:** _________________________

Preferences

Online Services: If you would like online access, please select which online services you would like to be signed up for.	**Would you like to register for online access?** Appointment booking [ ] Ordering Medication [ ] View Medical Record [ ] I **Do Not** Want Online Access [ ]
Electronic Prescription Service The electronic prescription service saves allows your GP to send your prescription directly to your pharmacy of choice without you needing to attend the surgery. The choice of pharmacy can be changed at any time. If you wish to know more please ask a member of staff.	**Would you like to nominate a pharmacy for your GP to send your prescriptions to?** Nominated Pharmacy name: __________________________ Pharmacy Address: ________________________________ ____ ____
Patient Participation Group Would you like to be involved in improving the services we offer to our patients? For more information, ask our receptionists.	**Would you like to join our patient participation group?** **YES [ ]** **NO [ ]**

Significant Medical History

Physical or Mental Health Needs

Do you consider any of the following to apply to you?

[ ] Deafness or serious hearing loss

[ ] Blindness or serious sight loss

[ ] Wheelchair user or impaired physical mobility

[ ] Mental disability (please specify): ____________________

[ ] None of the above

Past History

Have you ever had:

Diabetes		High blood Pressure		Asthma	
Heart Disease		Stroke		Tuberculosis (TB)	
High cholesterol		Epilepsy		Mental Illness	

Cancer (please specify when diagnosed, type, etc.): ___________

____

Allergies

Are you allergic to any drugs?

NO [ ] **YES [ ]** If Yes, please name drug: __________

____

Are you allergic to anything else?

NO [ ] **YES [ ]** If Yes, please specify: ____________

____

Operations, Serious Illnesses or Accidents

Current Medications

Are you taking any medicines? If so, please list:

Lifestyle

Height and Weight	**Height:** __________ (cm) weight: ___________ **(kg)**
Smoking Status	**Do you currently smoke tobacco? YES [ ] No [ ]** **Have you ever smoked tobacco? YES [ ] No [ ]** **How many cigarettes per day did you /do you now smoke?** (Please complete even if you have stopped) _______________ **If you currently smoke, are you interested in stopping?** (please ask our receptionists for details) **YES [ ] NO [ ]**
Alcohol Consumption	**Please circle below the statements that apply to you**

How often do you have a drink containing 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?	1 - 2	3 - 4	5 - 6	7 - 9	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

Religious or Cultural Needs	**Do you have any religious or cultural needs that you feel your doctor should be aware of?** (If YES, please detail) ______________________________ ______________________________

Summary Care Record (SCR)

The SCR is an electronic patient summary containing important clinical information from the GP record that is accessible by authorised healthcare staff in an urgent or emergency situation.

Your Summary Care Record contains important information about any medicines you are taking, any allergies you suffer from and any bad reactions to medicines that you have previously experienced.

Allowing authorised healthcare staff to have access to this information will improve decision making by doctors and other healthcare professionals and has prevented mistakes being made when patients are being cared for in an emergency or when their GP practice is closed.

Your Summary Care Record also includes your name, address, date of birth and your unique NHS Number to help identify you correctly. You may want to add other details about your care to your Summary Care Record. This will only happen if both you and your GP agree to do this. You should discuss your wishes with your GP.

Summary Care Record	Are you happy to have a summary care record? YES [ ] NO [ ]

Signature

Name (please print)		**Date:**	
Signature:			