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_____/_____/_____

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

052019_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 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		
	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.

New Patient Registration Form (Children: under 16s)

Westbourne Grove Medical Centre

Complete a separate form for each child to be registered.

Once you complete the questionnaire, please give the form to receptionist or staff of our practice with proof of your address and a photo ID.

We accept a utility bill, a bank statement or tenancy agreement as the proof of your address. If you can not provide one of these documents, please speak to the receptionist or staff of our practice.

Parents

Please provide details of *BOTH* parents (if possible).	
Father's name:	**Mother's name**
Father's address:	**Mother's address:**
Father's telephone number:	**Mother's telephone number:**

Who has parental responsibility of the child?

☐ Both ☐ Father ☐ Mother ☐ Someone else (Please provide details in next section)

Next Of Kin

Please provide details of next of kin if different than parents.	
Name:	**Relationship to the child:**
Address:	**Telephone number:**

Does the next of kin has parental responsibility for the child?

☐ Yes ☐ No

Personal Details

Child's current status (if applicable):

☐ Homeless
☐ Refugee
☐ Asylum seeker

Child's ethnicity:

☐ White British ☐ White (other) ☐ Indian ☐ Pakistani ☐ White Irish ☐ Mixed ☐ Black Caribbean ☐ Black African ☐ Bangladeshi ☐ Chinese ☐ Other Asian(non-Chinese) ☐ Black(Others) ☐ Other

Disability & Carer Status

Does the child look after someone?
Let us know if the child is looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems.
☐ Yes ☐ No

Does the child have a disability?
☐ No ☐ Physical impairment ☐ Learning disability ☐ Mental health condition

Is someone looking after the child?
Let us know if a family member, friend or neighbour looks after the child.
☐ Yes ☐ No

Carer's name:	**Relationship to the child:**
Address of carer:	**Telephone number of carer:**

Communication And Access Needs

SMS Messaging Service:
Would you like to receive text message appointment reminders and other notices from our practice about the child?
☐ Yes ☐ No

Online services:
Do you want the child to be registered for the online services?
☐ Yes ☐ No

Does the child use hearing aid?
☐ Yes ☐ No

Does the child use sign language?
☐ Yes ☐ No

Does the child need an interpreter?
☐ Yes ☐ No
Which language?

Medical History

Please give us as much information as possible about the child's medical conditions including **year of diagnosis and treatment**. Please leave the textbox empty if the child does not have any medical condition.

Chronic Condition	Details including year of diagnosis	Treatment
Medical conditions: ☐ Asthma ☐ Diabetes ☐ Epilepsy ☐ Other		
Operations:		
Mental health conditions: ☐ Depression/Anxiety ☐ Autism/ADHD ☐ Other		
Cancer: ☐ On active treatment ☐ Past treatment ☐ Other		
Allergy: ☐ Drug allergy ☐ Non-drug allergy		

Immunisation

Please give full details of the child's immunisation. The practice will not be able to register the child without this information.

When	Diseases protected against	Vaccine given and trade name		Date(DD/MM/YY)	GP Surgery	Private	Abroad
Eight weeks old	Diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenzae type b (Hib) and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa		☐	☐	☐
	Meningococcal group B (MenB)	MenB	Bexsero		☐	☐	☐
	Rotavirus gastroenteritis	Rotavirus	Rotarix		☐	☐	☐
Twelve weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa		☐	☐	☐
	Pneumococcal (13 serotypes)	PCV	Prevenar 13		☐	☐	☐
	Rotavirus	Rotavirus	Rotarix		☐	☐	☐
Sixteen weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa		☐	☐	☐
	MenB	MenB	Bexsero		☐	☐	☐
One year old(on or after the child's first birthday)	Hib and MenC	Hib/MenC	Menitorix		☐	☐	☐
	Pneumococcal	PCV booster	Prevenar 13		☐	☐	☐
	Measles, mumps and rubella (German measles)	MMR	MMR VaxPRO or Priorix		☐	☐	☐
	MenB	MenB booster	Bexsero		☐	☐	☐
Eligible paediatric age group	Influenza(each year from September)	Live attenuated influenza vaccine LAIV	Fluenz Tetra		☐	☐	☐
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	dTaP/IPV	Repevax or Boostrix-IPV		☐	☐	☐
	Measles, mumps and rubella	MMR (check first dose given)	MMR VaxPRO or Priorix		☐	☐	☐
Boys and girls aged twelve to thirteen years	Cancers caused by human papilloma virus (HPV) types 16 and 18 (and genital warts caused by types 6 and 11)	HPV (two doses 6-24 months apart)	Gardasil		☐	☐	☐
Fourteen years old (school year 9)	Tetanus, diphtheria and polio	Td/IPV (check MMR status)	Revaxis		☐	☐	☐
	Meningococcal groups A, C, W and Y disease	MenACWY	Nimenrix or Menveo		☐	☐	☐

Repeat Medications

If the child is on any repeat medications, then please hand in repeat prescription slip from the previous GP at our surgery reception. If you do not have repeat prescription slip, then list any current medication the child taking and make sure you show reception all medications in their original packaging and labelling. We may need to contact your child's previous GP surgery to confirm the medications.

Family Medical History

Please give us as much information as possible about the family history of listed medical conditions including child's relation to the family member. Please leave the textbox empty if the child does not have family history of this medical condition.

Condition	Details
☐ Asthma ☐ Diabetes in children ☐ Heart condition in children ☐ Epilepsy in children ☐ Cancer in children ☐ Other	

Hospital Care

If the child is currently under hospital care, please give details of name of Hospital, name of consultant and nature of problem.

Sharing of Child's Medical Record

Medical Record Sharing allows the child's complete GP medical record to be made available to authorised health professionals involved in the child's care. You will always be asked your permission before anybody looks at the child's shared medical record.
If you don't want to share the child's GP record tick here: ☐

Summary Care Record contains details of the child's key health information - medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. You will always be asked your permission before anybody looks at the child's Summary Care Record.
If you don't want the child to have a Summary Care Record tick here: ☐

The Care.data Programme collates information about the child and the care child receives. It links information from all the different places where the child receives care, such as your GP, hospital and community services, to help them provide a full picture of the child's medical needs and the care the child is receiving. This data is made available to NHS Commissioners so that they can design integrated services and is shared with third parties for research purposes.
I wish to OPT OUT from the child's Personal Confidential Data being shared outside their GP practice: ☐
I wish to OPT OUT from the child's Personal Confidential Data being shared with *third parties:* ☐

I confirm information given on this form is correct to the best of my knowledge.

Signature of parent/guardian:_____ Date:_____