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

NHS 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

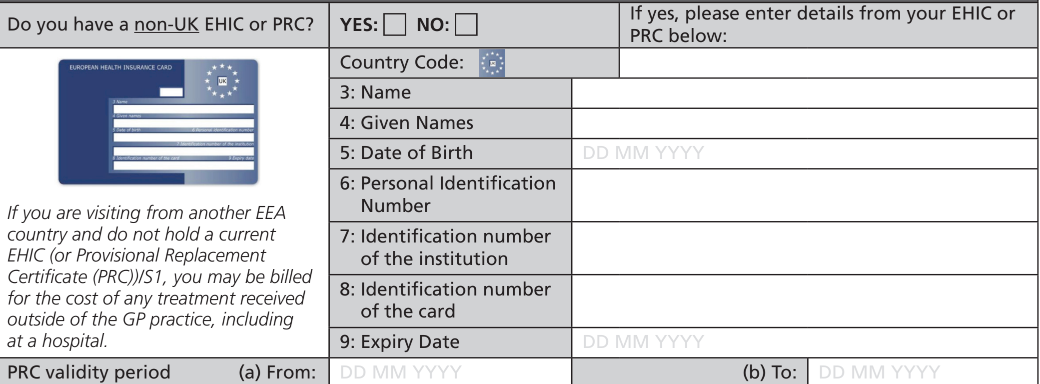
I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

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:
	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	
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.	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.

WHITELADIES MEDICAL GROUP

Patient Registration Form

Please complete both sides of the questionnaire as accurately as possible.

Name: ……………………………………………………………………

Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐ ………………

Address:
(Including Postcode) ……………………………………………………………………

……………………………………………………………………

Date of Birth: ……………………………………………………………………

Home Telephone Number: ……………………………………………

Work Telephone Number: ……………………………………………

Mobile Telephone Number: ……………………………………………

EMAIL ADDRESS:……………………………………………………………………

Religion: ……………………………………………………………………

Smoking:

Have you ever smoked tobacco?	YES ☐	NO ☐
If YES to previous question, do you still smoke?	YES ☐	NO ☐
If you no longer smoke, when did you quit?	…………………	
How much do you/did you smoke per day?	…………………	
Do you know we offer help to stop smoking?	YES ☐	NO ☐
Would you like smoking cessation advice?	YES ☐	NO ☐

Alcohol:
How much alcohol do you drink in an average week?
Pints of beer/lager? …………………………
Glasses of wine? …………………………
Spirits? (pub measure - please see reverse) …………………………
Teetotal? …………………………

Allergies:
Are you allergic to any drugs, medicines or dressings? YES ☐ NO ☐
If yes, please give details: ……………………………………………………

Exercise:
How much exercise do you take a week? (please tick)

Nil	☐
Less than 1 hour (light exercise)	☐
1 ½ - 4 hours (moderate exercise)	☐
Over 4 hours (heavy exercise)	☐

Height: ……………………………………………………………………
Weight: ……………………………………………………………………

Next of Kin: Name: ……………………………………………………

Please Specify Relationship: ……………………………………………………

Contact Telephone Number: ……………………………………………………

The name and number of your next of kin will be added to your medical record.

Female Patients Only:
Date of last smear:

Family History: Please tick to indicate the family member, problem and age.

Mother	Under 60	Over 60
Heart Problems	☐	☐
Glaucoma	☐	☐
High Blood Pressure	☐	☐
Cancer (please specify):	☐	☐

……………………………………………

Father	Under 60	Over 60
Heart Problems	☐	☐
Glaucoma	☐	☐
High Blood Pressure	☐	☐
Asthma	☐	☐
Cancer (please specify):	☐	☐

……………………………………………

Grandmother	Under 60	Over 60
Heart Problems	☐	☐
Glaucoma	☐	☐
High Blood Pressure	☐	☐
Asthma	☐	☐
Diabetes	☐	☐
Cancer (please specify):	☐	☐

……………………………………………

Grandfather	Under 60	Over 60
Heart Problems	☐	☐
Glaucoma	☐	☐
High Blood Pressure	☐	☐
Asthma	☐	☐
Diabetes	☐	☐
Cancer (please specify):	☐	☐

……………………………………………

Brother	Under 60	Over 60
Heart Problems	☐	☐
Glaucoma	☐	☐
High Blood Pressure	☐	☐
Asthma	☐	☐
Diabetes	☐	☐
Cancer (please specify):	☐	☐

……………………………………………

Sister	Under 60	Over 60
Heart Problems	☐	☐
Glaucoma	☐	☐
High Blood Pressure	☐	☐
Asthma	☐	☐
Diabetes	☐	☐
Cancer (please specify):	☐	☐

……………………………………………

WHITELADIES
MEDICAL GROUP

Communications Consent

Text Message Service: We use our text messaging service to send test results, communicate directly to patients regarding their health, appointment reminders, clinic invitations (e.g. flu, asthma, COPD) and for health promotion campaigns (e.g. stop smoking support).

All registered patients will receive appointment reminders and invitations*. But we will only text you messages from clinicians and test results if you explicitly consent to this.

If you do consent, please ensure you have entered your mobile number on the first page of this form.

☐ **I CONSENT TO RECEIVE TEXT MESSAGES ABOUT MY HEALTHCARE**

☐ **I DO NOT WISH TO RECEIVE TEXT MESSAGES ABOUT MY HEATHCARE**

**If you don't wish to receive any messages at all please inform a member of staff.*

E-mail Address: Please tick if you would not like to receive general health service information from us*.

☐ **I CONSENT TO RECEIVE EMAILS ABOUT GENERAL HEALTH SERVICE INFO**

Your email address:____

**Your e-mail address will not be disclosed to anyone else.*

Whiteladies Medical Group

Are you a Carer?

Are you a Carer? Yes ☐ No ☐

If yes, please give details of the person who you care for:

Name of person you care for: ……………………………………………………………………

Relationship of person who you care for: ……………………………………………………

Medical condition of person you care for: …………………………………………………...

Is the person you care for a registered patient of this surgery? Yes ☐ No ☐

Do you want more information on the benefits of being a carer? Yes ☐ No ☐

Are you cared for by a Carer?

Are you cared for by a Carer? Yes ☐ No ☐

If yes, please give details of the person who cares for you:

Carers name: ………………………………………………………………………………………

Carers relationship to you: ………………………………………………………………………

Carers contact details: ……………………………………………………………………………

………

Telephone number: ………………………………………………………………………………

Is the person who cares for you, a registered patient of this surgery? Yes ☐ No ☐

If you would like more information on Carers and being a Carer, please ask at the reception desk for a Carer's Information Pack

WHITELADIES MEDICAL GROUP

Alcohol Users Disorders Identification Test (Audit)

Units of Alcohol:

1 x pint of beer/lager/cider	2 units
1 x bottle of alcopop or can of lager	1.5 units
1 x 175ml glass of wine	2 units
1 x single measure of spirits	1 unit
1 x bottle of wine	9 units

Questions:	Scoring System					Your Score
	0	1	2	3	4	
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 standard alcoholic drinks do you have on a typical day when you are drinking?	1 – 2	3 – 4	5 – 6	7 – 8	10 +	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you found you were not able to stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you needed an alcoholic drink in the morning to get you going?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you had a feeling of guilt or regret after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often in the last year have you not been able to remember what happened when drinking the night before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or someone else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative/friend/doctor/health worker been concerned about your drinking or advised you to cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0–7 = Sensible drinking; 8–15 = hazardous drinking; 16–19 = harmful drinking; 20+ = possible dependence

Updated Nov 2020

WHITELADIES MEDICAL GROUP

Patient Profiling Form

Practice / GP: ……………………………………………………… Date of Birth: ………………………

Patient Name: ……………………………………………………… Post Code: ………………………

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1. What do you consider to be your ethnic origin?

Asian or Asian British
- ☐ Bangladeshi
- ☐ Indian
- ☐ Pakistani
- ☐ Asian other (please state)

…………………………………………………………

White
- ☐ British
- ☐ Irish
- ☐ White other (please state)

…………………………………………………………

Black or Black British
- ☐ African
- ☐ Somali
- ☐ Caribbean
- ☐ Black other (please state)

…………………………………………………………

Other Ethnic Group
- ☐ Chinese
- ☐ Any other (please state)

…………………………………………………………

Mixed Background
- ☐ White and Asian
- ☐ White and Black African
- ☐ White and Black Caribbean
- ☐ Other mixed background (please state)

…………………………………………………………

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2. In the clinic, which language do you usually speak and read?

Speaking	Reading	
☐	☐	English
☐	☐	Albanian
☐	☐	Bengali
☐	☐	Cantonese
☐	☐	Farsi
☐	☐	French
☐	☐	Gujarati
☐	☐	Hindi
☐	☐	Mandarin

Speaking	Reading	
☐	☐	Polish
☐	☐	Punjabi
☐	☐	Russian
☐	☐	Somali
☐	☐	Spanish
☐	☐	Turkish
☐	☐	Urdu
☐	☐	Other (please state)

…………………………………………………

Thank you for helping us.

☐ I do not wish to complete this form.

If you need this document in a different format please telephone 0117 900 2287.

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