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

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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:**	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.

Dr Shimmins and Partners
NEW PATIENT QUESTIONNAIRE

Please complete clearly in BLOCK CAPITALS the following for our records:

TITLE:	**Mr ☐ Mrs ☐ Ms ☐ Miss ☐ *(please tick)***	
SURNAME:		
FORENAME(S):		
MAIDEN NAME:		**Next of Kin:**
DATE OF BIRTH:		
HOME TELEPHONE NUMBER:		
MOBILE NUMBER:		
CURRENT ADDRESS:		

Online Services

*If you would like to register for our **Online Services**, please ask the Receptionist for an Online Registration Form. Please note that you will need to provide 2 proofs of Identification which must consist of a photographic ID such as a passport or driving licence and one proof of address such as a financial statement or utility bill. Online registration is for over 16's only.*

Mobile Telephone Text Messages

We operate a text messaging service for appointment and regular medical review recalls. If you wish to receive these reminders please tick the box ***Opt in for Text reminders*** ☐

Ethnic Origin

White ☐ White – Other ☐ *Please specify* …… Black – African ☐ Black – Caribbean ☐

Black – Other ☐ *Please specify* …….. .. Indian ☐ Pakistani ☐ Bangladeshi ☐

Chinese ☐ Asian – Other ☐ *Please specify* …… *None of the above – Please specify* ……

If you have had any operations, serious accidents or illnesses lasting more than 2 weeks in the last 10 years; please list below:

Approx. date	Nature of illness	Hospital attended

Please list any medication you are currently taking or during the past two years:

NAME OF DRUG(S)	DOSE	FREQUENCY ie daily, twice daily etc

***Please continue on the back of this page if you have more than 5 repeat medications.**

GENERAL INFORMATION** **(please tick all that apply)

Do you wear spectacles or contact lenses? Yes ☐ No ☐

Are you allergic to any drugs? Yes ☐ No ☐ If Yes which drugs ……

Do you have any disability? Yes ☐ No ☐ *if Yes please specify*……..

Do you have any current health problems? Yes ☐ No ☐

Have you ever had: a) raised blood pressure? Yes ☐ No ☐ b) kidney disease? Yes ☐ No ☐

c) sugar in your urine? Yes ☐ No ☐ d) jaundice? Yes ☐ No ☐

e) heart disease? Yes ☐ No ☐ f) depression or other mental health problems? Yes ☐ No ☐

SMOKING STATUS ***(please tick boxes that apply to you)***

Current Smoker ☐ Cigarettes ☐ how many ……..
Tobacco ☐ how much ……..
Cigars ☐ how many ……..
Pipe smoker ☐ how much ……..

Ex-Smoker ☐ Date stopped (approx.) ……..

Never Smoked ☐

MILITARY VETERENS

Army ☐ Navy ☐ Air Force ☐ Reserve Services ☐ Date left service ……..

FAMILY HISTORY ***(Please tick all that apply to you)***

Have your parents, grandparents, brothers or sisters suffered from any of the following serious illnesses:

a) Heart disease Yes ☐ No ☐ b) Diabetes Yes ☐ No ☐ c) Glaucoma Yes ☐ No ☐
d) High blood pressure Yes ☐ No ☐ e) Stroke Yes ☐ No ☐ f) Cancer Yes ☐ No ☐
breast, colon or prostate

g) Any other (please list) ……

If you answered "YES" to any of the above questions please make an appointment to discuss with the GP or Practice Nurse.

CARER

Are you a carer for an elderly or sick relative, who is also a patient at this Practice? Yes ☐ No ☐
If so, please ask at Reception for a Carer Identification Form.

FOR WOMEN PATIENTS ONLY

Have you been immunised against German Measles Yes ☐ No ☐
Have you ever had a cervical smear test Yes ☐ No ☐ if yes date of last smear test ……..
Are you taking the contraceptive pill Yes ☐ No ☐ if yes, please give name of pill ……..

FOR CHILDREN ONLY

Has your child been immunised against any of the following:

Poliomyelitis	Yes ☐	No ☐	Tetanus	Yes ☐	No ☐	Diphtheria	Yes ☐	No ☐
Whooping Cough	Yes ☐	No ☐	Measles	Yes ☐	No ☐	Rubella	Yes ☐	No ☐
BCG (Tuberculosis)	Yes ☐	No ☐	HIB	Yes ☐	No ☐	Pneumonia	Yes ☐	No ☐

FOR ADULTS ONLY

Please complete the attached Alcohol Intake Form.

NHS data sharing services (for more information on how the NHS collect data please go to www.hscic.gov.uk/forthepublic).

This form should be completed together with a Purple registration form (GMS1 form). Please note that failure to complete these forms fully could result in a delay in your registration process to this practice.

Using the "Unit guide" below, please complete the following Alcohol audits:

UNIT GUIDE

1 unit is typically:

Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)

The following drinks have more than one unit:

A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" lager, 250ml glass of wine (12%) or a bottle of

AUDIT- C Questions	Scoring system					Your score
	0	1	2	3	4	
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	
					TOTAL :	

If you scored **less than 5** please ignore the next 7 questions and continue with the form below. If you **Scored 5 and above**, please complete the following 7 questions.

AUDIT Questions (after completing 3 AUDIT-C questions above)	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody 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 or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					TOTAL	

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or see our website: www.drshimminsandpartners.nhs.uk