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_____/_____/_____

What is your ethnic group?

Please tick one box that best describes your ethnic group or background from the options below:

White: ☐ British ☐ Irish ☐ Irish Traveller ☐ Traveller ☐ Gypsy/Romany ☐ Polish
☐ Any other white background (please write in):

Mixed: ☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian
☐ Any other Mixed background (please write in):

Asian or Asian British: ☐ Indian ☐ Pakistani ☐ Bangladeshi
☐ Any other Asian background (please write in):

Black or Black British: ☐ Caribbean ☐ African ☐ Somali ☐ Nigerian
☐ Any other Black background (please write in):

Other ethnic group: ☐ Chinese ☐ Filipino
☐ Any other ethnic group (please write in):

Not stated: ☐
Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to.

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

Practice Stamp

Authorised Signature

Name

Date _____/_____/_____

SUPPLEMENTARY 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 an EU 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 Business Service Authority for the purpose of recovering your NHS costs from your home country.

SHEPHALL
HEALTH CENTRE

Ridlins End, Stevenage, Herts SG2 9QZ

□: 01438 312097 □: www.shephallwaysurgery.co.uk

We welcome you to our practice. Please complete the form below AND the GMS1 form

ADULT PATIENT REGISTRATION FORM

Full name (including title):	
Address:	
Date of birth:	
Telephone number(s)	
Email address:	
Gender: (Male/Female/Other)	
Marital Status	
NHS Number (if known)	
Country of origin:	
Main language spoken:	
Do you require an interpreter? Please state language required	
If you are in education Name of playschool, nursery, school, college	
Are you a Carer? If so, give details	
Details of previous GP	

White	British	☐	Irish	☐	Other	☐		
Mixed	White & Black Caribbean	☐	White & Black African	☐	White & Asian	☐	Other	☐
Asian or Asian British	Indian	☐	Pakistani	☐	Bangladeshi	☐	Other	☐
Black or Black British	British	☐	Caribbean	☐	African	☐	Other	☐
Other	Chinese	☐	Other	☐				

Names and details of family members currently living with you:

Name	Date of Birth	Relationship

Basic Health Information

Height cm's / ft & ins		Weight kg / stones & lbs	

Exercise: Heavy ☐ Moderate ☐ Light ☐ Never ☐ Please tick appropriate box
Diet: Healthy and Varied ☐ Vegetarian/Vegan ☐ Could be better ☐ Please tick appropriate box

Do you have any allergies? (e.g. penicillin, nuts etc) **Yes ☐ No ☐ if YES please specify**	

Vaccination Status:

Have you received any of the following vaccinations?

Vaccine	Date	*Don't know*
Tuberculosis (BCG)		☐
Hepatitis A/B/E		☐
Malaria		☐
MMR		☐
Rotavirus		☐
Tetanus		☐
Meningitis C		☐
Diphtheria		☐
Polio		☐
Whooping cough		☐
HPV (human papillomavirus)		☐
Hib		☐
Pneumonia		☐
Typhoid		☐
COVID-19		☐

Other/Comments:

Smoking Status

Smoking: Do you smoke?

- No, never smoked ☐
- Yes, amount smoked per day ☐

Have you been offered any stop smoking advice in the past year? Yes ☐ No ☐

Ex-smokers: How old were you when you stopped?
How many did you smoke per day?

Alcohol

	Pint of regular beer/lager/cider	Alcopop or can of beer/lager/cider	Glass of wine (175 ml)	Single measure of spirits	Bottle of wine
Units					

Points	0 points	1 point	2 points	3 points	4 points	Your score
How often do you have a drink that contains alcohol?	Never	Less than monthly	Monthly	Weekly	Most days	
How many standard alcohol drinks do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-8	9+	
How often do you have 6 or more standard drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Most days	
					TOTAL =	

Medical History:

Please indicate (tick) if you have ever suffered from any of the following:

High blood pressure	☐	Diabetes	☐	Heart disease	☐	Asthma	☐
Mental illness	☐	Stroke	☐	Urinary problems	☐	Skin disorders	☐
Joint disorders	☐	Bowel disease	☐	Glaucoma	☐	COPD	☐
Kidney disease	☐	Cancer (please specify)	☐	Epilepsy *(Date of last fit if you ticked this)*	☐	Tuberculosis	☐
Do you have any mobility issues or requirements?							
Other – please specify:							

Additional questions for female patients:

Are you currently pregnant? Yes ☐ No ☐	**Due Date:**
Date of last cervical smear:	**Contraception:**
Date of last mammogram:	**HRT:**
Hysterectomy: Yes☐ No☐	**Breast Disease:** Yes☐ No☐ (if yes, date and details)

Family History

Please advise if any of your immediate family suffered from any of the conditions listed above in 'Medical History'.

Relationship to you of family member:	
Condition(s):	
Relationship to you of family member:	
Condition(s):	
Relationship to you of family member:	
Condition(s):	
Relationship to you of family member:	
Condition(s):	

Are you on regular medication? If so, please give drug name, strength and dose

1.	
2.	
3.	
4.	
5.	
Other:	

Signed: _____ Date: _____

Capacity: Patient / Legal Guardian (please indicate).

Information for new patients: about your Summary Care Record

Dear patient,

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have a choice
You have the choice of what information you would like to share and with whom. Authorised healthcare staff can only view your SCR with your permission. The information shared will solely be used for the benefit of your care.

Your options are outlined below; please indicate your choice on the form overleaf.

☐ **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only.

☐ **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

☐ **Express dissent for Summary Care Record (opt out).** Select this option, if you **DO NOT** want any information shared with other healthcare professionals involved in your care.

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions.

Once you have completed the consent form, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

Summary Care Record patient consent form

Having read the above information regarding your choices, please choose **one** of the options below and return the completed form to your GP practice:

Yes – I would like a Summary Care Record

□ Express consent for medication, allergies and adverse reactions only.

or

□ Express consent for medication, allergies, adverse reactions and additional information.

No – I would not like a Summary Care Record

□ Express dissent for Summary Care Record (opt out).

Name of patient: .....

Date of birth: ..... Patient's postcode: .....

Surgery name: ..... Surgery location (Town): .....

NHS number (if known): .....

Signature: ..... Date: .....

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; you sign the form above and provide your details below:

Name: .....

Please circle one: Parent / Legal Guardian / Lasting Power of Attorney

For more information, please visit https://www.digital.nhs.uk/summary-care-records/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice.

For GP practice use only

To update the patient's consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.

Summary Care Record consent preference	Read 2	CTV3
The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only)	**9Ndm**	**XaXbY**
The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information)	**9Ndn**	**XaXbZ**
The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out)	**9Ndo**	**XaXj6**