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_____/_____/_____

Please see overleaf re: Organ donation

NHS

Family doctor services registration

GMS1

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:

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

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

SHEPHALL HEALTH CENTRE

Ridlins End, Stevenage, SG2 9QZ

NEW PATIENT HEALTH QUESTIONNAIRE – CHILD UNDER 5

Thank you for your interest in registering your child under the age of 5 with this surgery.
To register with the practice please complete form below and the GMS1 form.
Complete one of these registration forms for **EACH** new patient **under the age of 5.** We ask that you complete all sections carefully and give as much information as possible. Your application to register may be delayed if they are returned incomplete.

Title (Mr/Mrs/Miss/Ms/other)	
Surname	
Forename	
Date of birth	
Male / female	
NHS number	
Address and postcode	
Mother's full name **Contact telephone number**	
Father's full name **Contact telephone number**	
Guardian/foster carer's full name **Contact telephone number** **(Please provide letter)**	
Name of playschool, **nursery or school**	
Name of previous GP **Address of previous GP surgery**	
Have you been registered with us before?	
Name of previous Health Visitor	

SIGNED DECLARATION (MUST BE SIGNED)

I certify that the statements and facts made in this new patient questionnaire are true to the best of my knowledge.

1. All patients over the age of 15 must sign for themselves.
2. All patients under the age of 15 must be signed for by their parent or legal guardian.

Please tick the box on the right if you consent to being contacted from time to time via email and/or SMS text message with news about the practice ☐

Please tick the box on the right if you consent to being contacted from time to time via email and/or SMS text message with advice about your health and/or appointment reminders. We will be unable to send reminders unless you tick this box ☐

Signed: _____ Date: _____

Capacity: Patient / Legal Guardian (please indicate).

BRIEF MEDICAL HISTORY

Please supply a very **brief history of any medical problems**, so that we have some record (in the event of you having to be seen by a doctor) before your notes arrive at the surgery. Please list any conditions that took you into hospital, any operations, and any important or continuing conditions.

ALLERGIES

Please state if you suffer from any allergies.

No	Please here tick if none
Yes	Please enter details here if you have allergies:

CHILDHOOD IMMUNISATIONS

Please list any immunisations your child has had and the dates they were given in the box below (Immunisation dates can be found in the red book)

TRANSFER INFORMATION FORM FOR HEALTH VISITORS

(under 5 years old)

NB: Not applicable for new born babies or families currently registered.

Date	
Name of Surgery	Shephall Health Centre
Childs Name	
D.O.B.	
Male/Female	
Age	
Mothers Name	
Mothers D.O.B.	
Present Address including post code	
Previous Surgery Including address	

Immunisations (please give dates)

1st Primary……..

2nd Primary ……..

3rd Primary…….

Hib. Men C

Hep B……..

MMR……

Pre-School Booster…….

Other……

Would you like a Health Visitor to contact you regarding any current problems?

Contact Telephone number for Health Visitor – 01438 845606