WELLINGTON
Medical Practice

New patient registration – please complete all pages

Full Name:		
Date of Birth:		
Address and Postcode:		
Telephone Number:		
Work Number:		
Mobile Number:		
Email Address:		
NHS Number:		
Town & Country of Birth:		
Next of Kin Details:		
Can we discuss your medical Record with your Next of Kin?	Yes	No
Are you happy to receive text messages from the Surgery?	Yes	No
Can the Surgery leave you voicemails on the numbers you have provided?	Yes	No

If under 18 are you a looked after child?	Yes	No
If Yes, Please state name and phone number of main carer.		
Additional Information for Patients under the Age of 5 only		
Birth Weight		
Type of Delivery		
At what Gestation was the baby born?		

Please tick your ethnicity below

- ◯ White - British
- ◯ White - Irish
- ◯ White - Other
- ◯ Mixed - White and Black Caribbean
- ◯ Mixed - White and Black African
- ◯ Mixed - White and Asian
- ◯ Mixed - Other mixed groups
- ◯ Asian or Asian British - Indian
- ◯ Asian or Asian British - Pakistani
- ◯ Asian or Asian British - Bangladeshi
- ◯ Asian or Asian British - Other Asian Background
- ◯ Black or Black British - Caribbean
- ◯ Black or Black British - African
- ◯ Black or Black British - Other Black Background
- ◯ Chinese
- ◯ Any other ethnic group

What is your first language?		
Do you require an interpreter?	Yes	No

Health And Medical Background	
What is your Height?	
What is your weight?	
Please list any long standing medical conditions?	
Do you currently take any medication? If yes please give details.	If you have a copy of your repeat medications please attach to this form
Do you consider yourself as disabled? Please specify	
Do you have a Learning disability? Please specify	

Do you have any allergies? Please specify	

Are there any serious illnesses that affect your parents or siblings?	Diabetes	Heart attack after 60	Heart attack before 60
	Breast Cancer	High Blood Pressure	Asthma
	Stroke	Bowel Cancer	Thyroid disorder

Smoking and Alcohol Status		
Are you a current Smoker?	Yes	No
Have you ever smoked?	Yes	No
How many do you, or did you smoke a day?		
Do you use an e-cigarette or vape?	Yes	No
If you are a current smoker do you want information about smoking cessation services?	Yes	No
Do you drink Alcohol?	**Yes**	**No**
How many units do you drink a week?		

	0	**1**	**2**	**3**	**4**
How often do you drink more than 6 units in a day?	Never	Monthly or less	Monthly	Weekly	Daily or nearly daily
How often do you have a drink that contains Alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a week
How many units do you have on a day that you drink Alcohol	0 - 2 drinks	3 – 4 drinks	5 – 6 drinks	7 – 9 drinks	10+ drinks

Your Named GP at Wellington Medical Practice will be one of the following GPs	**Dr T O Brien, Dr D Ebenezer, Dr N Singh, Dr J Ebenezer or Dr R Kaur**

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**

GMS1_112018_005 Family Doctor Services Registration_tearoff.indd 1 27/06/2019 15:08

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.

Summary Care Record (SCR) – The NHS has changed the way your information is shared among NHS hospitals and Doctors. The SCR is made up of two parts. **1) Basic – Allergies and Medications** **2) Additional Information – Allergies, Medications and Health problems** **Do you want to have a SCR created – PLEASE CIRCLE**		
Basic	Additional Information	No, I do not want a SCR

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 that 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.

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

b) **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies and adverse reactions and further medical information that includes: Your significant 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.

c) **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.

Please note that it is not compulsory for you to complete this consent form. If you choose not to complete this form, a Summary Care Record containing information about your

medication, allergies and adverse reactions and additional further medical information will be created for you as described in point b) above.

The sharing of this additional information during the pandemic period will assist healthcare professionals involved in your direct care and has been directed via the Control of Patient Information (COPI) Covid-19 – Notice under Regulation 3(4) of the Health Service Control of Patient Information Regulations 2002.

If you choose to complete the consent form overleaf, 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: ……

Address: ……

Postcode: …… Date of Birth: ……

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 health and welfare

If you require any more information, please visit http://digital.nhs.uk/scr/patients or phone NHS Digital on 0300 303 5678 or speak to your GP practice.

FINAL CHECKLIST BEFORE RETURNING FORMS BACK TO PRACTICE

All pages have been completed including Summary care records	
A copy of any repeat medications has been attached	
A copy of ID has been attached if possible e.g. Driving License, Passport, ID card, Utility Bill (this will help ensure the registration details match up)	

All 8 pages as well as any attachments can now be:
Returned by post to : Wellington Medical Practice, Chapel Lane, TF1 1PZ
Posted into out external letter box at the practice

Reception Checklist – For OFFICE USE ONLY

Item	**Initials**
Have all sections of the purple form been completed?	
If born outside of the UK have the supplementary questions been answered?	
Have all the questions been answered on this sheet?	
Have you informed the patient of their named GP?	
Have you taken photocopies of ID?	
Have you checked the address is within the catchment area?	

Date registration received:	
Date put on Computer:	