# 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*

☐ 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

**Not all doctors are authorised to dispense medicines*

☐ **Signature of Patient** ☐ **Signature on behalf of patient** Date

Version 01/02

*Please see overleaf re: Organ donation*

NHS

# Family doctor services registration

GMS1

## NHSOrgan Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

***Signature confirming consent to organ donation*** **Date**

*For more information, please ask for the leaflet on joining the NHS Organ Donor Register*

## NHSBlood 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 CHSlist 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

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**Walton Surgery**
**301 High Rd**
**Felixstowe**
**Suffolk**
**IP11 9QL**
**Tel:01394 278844**

******************************************************************

Welcome to our Practice

To enable us to register and provide you with appropriate health care please complete the form below. Please return this form to reception with GMS1 form.

**Name: …………………………………………………………………………………..**

**Address:……………………………………………………………………………...**

**Date of Birth:……………………….**

**Daytime Tel no:…………………….**

**Mobile:………………………………**

**Sex: Female / Male**

**Ethnic Origin (Please Tick)**

☐ **White** ☐ **Indian**
☐ **Black African** ☐ **Chinese**
☐ **Black Caribean** ☐ **Pakistani**
☐ **Bangladeshi** ☐ **Vietnamese**
☐ **Other** (please specify)**………………..**

**First Spoken language…………….**
**Occupation:………………………..**

**Next of kin:………………………..**
**Tel no of above:…………………...**

**Are you a carer of an immediate Family member? Yes / No**
**If Yes relationship to you………..**

**Height:…………………………………**

**Weight:………………………………**

**Do you smoke? Yes / No**
**If Yes How Many:……………………..**

**Have you ever smoked? If Yes when did you stop?........................................**

**How much alcohol do you drink each week? (1 unit = 1 glass of wine, 1 1 measure of spirit, ¼ pint of larger / beer……………………………………..**

**Do you Exercise? Yes / No**
**If Yes How often:………………………**

**Are you on regular contraception? Yes / No. If yes name of contraception ……………………………………………..**

**Last smear test:………………………...**
**Result of smear:……………………......**

**Do you suffer from any of the following? (Please circle)**

**Coronary heart disease Hypertension Diabetes Mellitus Cancer**

**Chronic Obstructive Pulmonary Disease Hypothyroidism Epilepsy**

**Asthma A Mental Health Problem e.g. Depression Other…………………..**

**Any Allergies:…………………….**

**What medication do you take? (Please specify and continue overleaf if necessary)**
**……………………………………………………………………………………..**