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

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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AINSDALE MEDICAL CENTRE
New Patient Information Form

Today's Date:

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Please complete a separate form for each family member to be registered.

Full Name:				**Telephone Number:**
Mr / Mrs / Miss / Ms / Other……..				**Work Number**
Address and Postcode				**Mobile Number:**
				Next of Kin: **Can we contact them in an emergency? Yes/No** **Next of Kin Contact Number:** **Next of Kin Relationship to you:**
Date of Birth:	**Previous / Mother's surname if different:**			
Age:	**Town & Country of Birth**			
Marital Status:		**Gender:**	**Male:** / **Female:**	**Other residents of your home:**
Occupation:				
Names & Ages of Children				**NHS Number (If Known)**

On Line Services: We encourage our patients to make use of our on-line services to order any repeat medications that they take and to book appointments.

Enclosed with your registration pack is an application form to enrol for Patient Access. Please complete the form and bring it to the surgery with two forms of current identification – one must carry a photograph and one your address.

If you would like to nominate a pharmacy for us to send your prescriptions to via the Electronic Prescription Service (EPS) please indicate the name below (note that you can change this or revert back to paper at any time),

Name of pharmacy:

If returning from Armed Forces:	**Your Service or Personnel Number**	**Your Enlistment Date**

Your Religion tick which applies:						
C of E	**Catholic**	**Jewish**	**Other Christian (state)**	**Buddhist**	**Hindu**	**Muslim**
Sikh	**Jehovah's Witness**		**Other religion (state)**	**No religion**	**Do not wish to disclose**	

Your Ethnic Origin: (select one)	**White (UK)** **9i0**	**White (Irish)** **9i1%**	**White (Other)** **9i2%**

Caribbean 9i3	African 9i4	Asian 9i5	Other Mixed Background 9i6%
Indian / Brit Indian 9i7	Pakistani / Brit Pakistani 9i8	Bangladeshi / Brit Bangladeshi 9i9	Other Asian Background 9iA%
Other Black Background	Chinese 9iE	Other 9iF%	Ethnic Category not stated 9iG

Is English your main or first language?	Yes	No	If no then what is your first language?

Smoking, Alcohol Consumption and Exercise:

Have you ever been a smoker?	Yes	No	Are you currently a smoker?	Yes	No
If so, how many cigarettes / cigars / tobacco do you smoke in a week?			How much alcohol do you drink in a week (Units)? *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)*		
If you are a smoker and want to stop, please ask for information about local smoking cessation services.					

How often do you exercise?	No. times per week	Type(s) of exercise:	

Your Medical Background:

What illnesses have you had & When?		
What operations have you had and When?		
Do you have any medical problems at present?		
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)		
Are you able to administer your own medicines?	Yes	No *(please detail specific issues e.g. swallowing, opening containers)*

Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)	Diabetes	Heart Attack	Heart attack under age of 60	Bowel Cancer	
	Breast Cancer		High Blood Pressure	Asthma	Stroke
	Thyroid Disorder		Any other important Family Illness?		

What immunisations have you had? (please tick all that apply)	Diphtheria	Measles	German Measles	Tetanus	Polio	MMR
	Whooping Cough		Pre-school booster	Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses		

Specific Needs: Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:	
Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):	
Are you an 'Assistance Dog' User?	
Please state any Physical disabilities you have:	
Please state any Mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises	
Please state any Religious or Cultural needs:	
Do you require the help of a Translator / Interpreter?	
Please state any specific nutritional requirements you have:	
Please state any allergies and sensitivities you have:	
Please state any phobias you have:	
If you are a Carer, please state the name / address / phone number of the person you care for:	**Person Cared For Contact Details:** Is this person a patient of our practice? Yes / No
If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.	**Carer Contact Details:** Is this person a patient of our practice? Yes / No
	I consent for you to disclose my health details to the above named person: **Signed:** **Date:**

Do you have a "Living Will" (a statement explaining what medical treatment you would not want in the future)?	Yes / No	***If "Yes", can you please bring a written copy of it to your New Patient Consultation***
Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	**Yes / No**	**If "Yes", please state their name / address / phone number: Please also provide a copy of the document for us to keep with your record.**

Women only:

When was your last smear done?	Date	Was this at your GP's Surgery?	Yes	NO
What was the result of the smear?				
Date of last mammogram (if applicable):	**Date**	**Method of contraception (if used):**		
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?			**Yes**	**NO**

Data Sharing

Sharing of medical records with other parties is becoming more common-place in healthcare. Many data sharing programmes are designed to help other health professionals look after you better by letting them see parts of your medical records. Other sharing schemes are designed to help better analysis of healthcare needs in order to make sure that appropriate services are provided to the population.

Please read the leaflet about data sharing that we have given you and complete the form accordingly. Unless you indicate otherwise by completing the preferences form you will be automatically INCLUDED in any sharing programmes in which Ainsdale Medical Centre participate.

Ainsdale Medical Centre is registered under the Data Protection Act

Patient Engagement

The Practice is committed to improving the services we provide to our patients.
To do this, it is vital that we hear from people about their experiences, views, and ideas for making services better.
We operate the NHS Friends and Family Test which is a patient satisfaction survey that also runs in hospitals. You can complete a survey form in the surgery or on-line via our website.Our results are published monthly.
We also run a Patient Reference Group (PRG) which is a small group of patients who meet about four times a year and in-between hold on-line discussion in a web forum. If you would like to join our PRG please contact the Practice manager who will be able to provide more information.

Patient Signature:	Name: Signature:	Signature on behalf of Patient:	

When you give us this completed form the Receptionist will make an appointment for your new patient check. All new patients over the age of 5 should attend a check. Your new patient check will include having your height, weight and blood pressure taken. We also ask you to bring with you a sample of your urine for us to send away for testing.

The Consultation will also establish relevant past history including medical and lifestyle factors

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.ainsdale-mc.co.uk