

## Patient's details

Please complete in BLOCK CAPITALS and tick  as appropriate

|                               |                                 |                               |                             |                    |
|-------------------------------|---------------------------------|-------------------------------|-----------------------------|--------------------|
| <input type="checkbox"/> Mr   | <input type="checkbox"/> Mrs    | <input type="checkbox"/> Miss | <input type="checkbox"/> Ms | Surname            |
| Date of birth                 |                                 |                               |                             | First names        |
| NHS No.                       |                                 |                               |                             | Previous surname/s |
| <input type="checkbox"/> Male | <input type="checkbox"/> 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

### 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](http://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: \_\_\_\_\_

HA use only    Patient registered for     GMS     CHS     Dispensing     Rural Practice



Family doctor services registration

GMS1

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

SUPPLEMENTARY QUESTIONS

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: <input type="checkbox"/> NO: <input type="checkbox"/> | If yes, please enter details from your EHIC or PRC below: |
|  <p><i>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.</i></p> | Country Code: <input type="text"/>                         |   |
|   | 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  |

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.

NEW PATIENT REGISTRATION FORM

|  |  |
|--|--|
| <b>Title:</b> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/><br>Master <input type="checkbox"/> Other _____<br><i>(Please tick)</i>  | <b>Surname:</b> _____<br><b>First Name:</b> _____<br><b>Middle Name(s):</b> _____<br><b>Previous / Surname:</b> _____  |
| <b>DOB:</b> _____ <b>Age:</b> _____  | <b>How many adults in the household:</b> .....<br><b>How many children in the household:</b> .....   |
| <b>NHS NO:</b> _____   | <b>Marital Status:</b> Single <input type="checkbox"/> Married <input type="checkbox"/> Co-habiting <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> |
| <b>Town of Birth:</b> _____  | <b>Country of Birth:</b> _____   |
| <b>Contact Details:</b> Home: _____<br>Mobile: _____   | Work: _____  |
| <b>Address:</b> _____<br><div style="text-align: right;"><b>Postcode:</b> _____</div>  |  |
| <b>Email:</b> _____  |  |
| <b>Previous address:</b> _____<br><div style="text-align: right;"><b>Postcode:</b> _____</div>   |  |
| <b>Previous Doctors:</b> _____<br><div style="text-align: right;"><b>Postcode:</b> _____</div>   |  |
| <b>NEXT OF KIN / EMERGENCY CONTACT DETAILS:</b><br><b>Name:</b> _____ <b>Relationship:</b> _____<br><b>Address:</b> _____<br>_____<br><b>Postcode:</b> _____ <b>Telephone:</b> _____<br><b>Is this person your carer:</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <b>If YES is this your main carer:</b> YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| <i>Repeat Medication: If you are on repeat medication please make an appointment with your registered Doctor within six weeks of registering. Please bring to the appointment a list of your current medications</i>   |  |
| <b><u>FOR OFFICE USE</u></b><br><b>Proof of Identification seen:</b> <input type="checkbox"/> <b>Type of document seen:</b> _____<br><b>Proof of residency seen:</b> <input type="checkbox"/> <b>Type of document seen:</b> _____<br><b>Checked by:</b> _____ <b>Date checked:</b> _____<br><b>Registered with Dr</b> _____ <b>Date of Registration:</b> _____                     |  |

## Ethnic Group – 16+1 codes

What is your ethnic group? Choose ONE section from A to E, then tick the appropriate box to indicate your ethnic group.

### A: White

- British
  - Irish
  - Any other White background (please write in)
- 

### B: Mixed

- White & Black Caribbean
  - White & Black African
  - White & Asian
  - Any other mixed background (please write in)
- 

### C: Asian or Asian British

- Indian
  - Pakistani
  - Bangladeshi
  - Any other Asian background (please write in)
- 

### D: Black or Black British

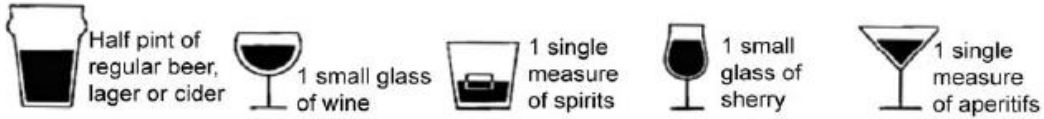
- Caribbean
  - African
  - Any other Black background (please write in)
- 

### E: Chinese or other ethnic group

- Chinese
  - Any other (please write in)
- 

- Not Stated

**This is one unit of alcohol...**



**...and each of these is more than one unit**



**AUDIT – C**

| Questions  | Scoring system |                   |                       |                      |                       | Your score |
|--|----------------|-------------------|-----------------------|----------------------|-----------------------|------------|
|  | 0              | 1                 | 2                     | 3                    | 4                     |            |
| How often do you have a drink containing alcohol?  | Never          | Monthly or less   | 2 - 4 times per month | 2 - 3 times per week | 4+ times per week     |            |
| How many units of alcohol do you drink on a typical day when you are drinking?                                 | 1 -2           | 3 - 4             | 5 - 6                 | 7 - 9                | 10+                   |            |
| How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year? | Never          | Less than monthly | Monthly               | Weekly               | Daily or almost daily |            |

|   |              |
|---|--------------|
| <p><b>Scoring:</b> A total of 5 indicates increasing or higher risk drinking. An overall total score of 5 or above is AUDIT–C positive.<br/>If you scored 5 or above please continue with the remaining questions below</p> | <b>Score</b> |
|---|--------------|

| Questions  | Scoring system |                   |         |        |                       | Your score |
|--|----------------|-------------------|---------|--------|-----------------------|------------|
|  | 0              | 1                 | 2       | 3      | 4                     |            |
| How often during the last year have you found that you were not able to stop drinking once you had started?                            | Never          | Less than monthly | Monthly | Weekly | Daily or almost daily |            |
| How often during the last year have you failed to do what was normally expected from you because of your drinking?                     | Never          | Less than monthly | Monthly | Weekly | Daily or almost daily |            |
| How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session? | Never          | Less than monthly | Monthly | Weekly | Daily or almost daily |            |
| How often during the last year have you had a feeling of guilt or remorse after drinking?  | Never          | Less than monthly | Monthly | Weekly | Daily or almost daily |            |
| How often during the last year have you been unable to remember what happened the night before because you had been drinking?          | Never          | Less than monthly | Monthly | Weekly | Daily or almost daily |            |

| Questions  | Scoring system |   |                               |   |                           | Your score |
|--|----------------|---|-------------------------------|---|---------------------------|------------|
|  | 0              | 1 | 2                             | 3 | 4                         |            |
| Have you or somebody else been injured as a result of your drinking?   | No             |   | Yes, but not in the last year |   | Yes, during the last year |            |
| Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down? | No             |   | Yes, but not in the last year |   | Yes, during the last year |            |

|  |              |
|--|--------------|
| <b>Scoring:</b> 0-7 Lower Risk, 8-15 Increasing Risk, 16-19 Higher Risk, 20+ Possible dependence | <b>Total</b> |
|--|--------------|

### Smoking Status

Please tick the entry which best describes your smoking status:

|                      |                |        |                          |
|----------------------|----------------|--------|--------------------------|
| Never Smoked Tobacco |                | (Tick) | <input type="checkbox"/> |
| Trivial Smoker       | < 1 cig/day    |        | <input type="checkbox"/> |
| Light Smoker         | 1-9 cigs/day   |        | <input type="checkbox"/> |
| Moderate Smoker      | 10-19 cigs/day |        | <input type="checkbox"/> |
| Heavy Smoker         | 20-39 cigs/day |        | <input type="checkbox"/> |
| Very Heavy Smoker    | 40+ cigs/day   |        | <input type="checkbox"/> |
| Pipe Smoker          |                |        | <input type="checkbox"/> |
| Passive Smoker       |                |        | <input type="checkbox"/> |
| Ex-Smoker            |                |        | <input type="checkbox"/> |

Number of Grams: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

DOB: \_\_\_\_\_

## Registering for Access to Online Services

Patient Access is a 24 hour online service that enables you to view, book and cancel appointments at both the Market Deeping and Glington Surgeries and order your repeat prescriptions from home, work or on the move — wherever you can connect to the internet, day or night, 24 hours a day.

In order to access the Patient Access services you are required complete the form below and hand it into your local surgery, where your application will be processed and a letter produced with your registration details.

This service is now available for children up to 13 years of age and for those who are 16 years of age and older. Parents / Guardians are able to register their children under the age of 13 years but once the child reaches their 13<sup>th</sup> Birthday this access will be removed along with the Mobile Number and Email address given below; this is to ensure that patient confidentiality is maintain as best as possible and you will receive prior notification from the Practice before this access is removed. The requesting parent/guardian must be registered at the same address as the child in order to access this service.

For now, this service is not available for 13 to 15 year olds, although they will be able to re-register in their own right from their 16<sup>th</sup> birthday.

### I would like to sign up for Online services

Patients Full Name:

Parent/Guardian's Full Name if application is for a child under 13:

Date of Birth:

Address:

Telephone No (Patient or Parent/Guardian if application is for a child under 13):

Email Address (Patient or Parent/Guardian if application is for a child under 13):

Mobile Number (Patient or Parent/Guardian if application is for a child under 13):

*(Please Tick)*

I will collect from the Surgery

Collection of Login Details:

Please Send them to the Registered Address

Signature (Patient or Parent/Guardian if application is for a child under 13): \_\_\_\_\_ Date: \_\_\_\_\_

For Office use:

Patient Record Update by:

Date:



## SMS (Short Message Service) Text Messaging Only for completion by patients aged 16 and over please

We are always looking at ways to improve our communication to patients.

SMS text messaging is currently being used by other organisations (including dentists, banks and schools) for appointment reminders and release of general information and we are able to use this facility, with your permission.

Care will be taken to ensure that no personal information is released using this service and the Practice will continue to observe the strictest controls with regard to holding your personal information in confidence.

Initially, an SMS text message will be sent containing your appointment details once you have booked an appointment. A further message will be sent 48 hours before the appointment is due as a reminder.

In the future, we will be looking to introduce a more interactive form of SMS text messaging which will allow you to cancel your appointment by text if you are no longer available to attend. This facility will also allow us to send you health promotion initiatives such as flu jabs and NHS Health Check invitations.

If you have a mobile phone, are over 16 and would like to receive SMS messages then please complete the slip below and hand it in at reception.

You may withdraw your consent at any time by notifying Reception either verbally or in writing.

---

I would like to receive SMS messages Appointment Reminders and in future Health Promotion initiatives when they are introduced.

I fully understand that it is my responsibility to provide The Deepings Practice with any change of mobile phone number.

Surname: \_\_\_\_\_

Forename(s): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

Address: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Disclaimer

If you agree to the Practice contacting you via the telephone number provided above, we agree to adhere to the following:

1. The telephone number you have provided will only be used by the practice in relation to the healthcare services offered by the practice. You will not be contacted in relation to any other types of products or services and your information will not be passed onto any other parties.
2. If at any time you would like to opt-out of the above service, please make a personal request to the practice and you will be opted out of the service within 48 hours. We would ask that you provide your reason for opting out to help us review and improve the service in the future.

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For Office use:

Patient Record Update by:

Date:





## Your emergency care summary

### New patient letter

Dear Patient

### Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care.

The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, healthcare staff treating you will have immediate access to important information about your health.

Your GP practice is supporting Summary Care Records and as a patient you have a choice:

- **Yes I would like a Summary Care Record** – you do not need to do anything and a Summary Care Record will be created for you.
- **No I do not want a Summary Care Record** – enclosed is an opt out form. **Please complete the form and hand it to a member of the GP practice staff.**

If you need more time to make your choice you should let your GP Practice know.

For more information talk to our Patient Advice and Liaison Service (PALS) on 0845 602 4384, GP practice staff, visit the website [www.lincolnshire.nhs.uk](http://www.lincolnshire.nhs.uk) or [www.nhscarerecords.nhs.uk](http://www.nhscarerecords.nhs.uk) or telephone the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

Additional copies of the opt out form can be collected from the GP practice, printed from the website [www.nhscarerecords.nhs.uk](http://www.nhscarerecords.nhs.uk) or requested from the dedicated NHS Summary Care Record Information Line on 0300 123 3020.

**You can choose not to have a Summary Care Record and you can change your mind at any time by informing your GP practice.**

If you do nothing we will assume that you are happy with these changes and create a Summary Care Record for you. Children under 16 will automatically have a Summary Care Record created for them unless their parent or guardian chooses to opt them out. If you are the parent or guardian of a child under 16 and feel that they are old enough to understand, then you should make this information available to them.

Yours sincerely,

The Deepings Practice



Your emergency care summary

CONFIDENTIAL

## OPT-OUT FORM

### Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice (completed forms must be returned to your GP practice. Forms sent anywhere other than your GP practice will not be actioned).

#### A. Please complete in BLOCK CAPITALS

Title ..... Surname / Family name .....

Forename(s) .....

Address .....

Postcode ..... Phone No..... Date of birth .....

NHS number (if known)..... Signature .....

**B. If you are filling out this form on behalf of another person or child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B**

Your name ..... Your signature.....

Relationship to patient..... Date .....

#### What does it mean if I DO NOT have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please:

- phone the Summary Care Record Information Line on 0300 123 3020;
- contact your local Patient Advice Liaison Service (PALS); or
- contact your GP practice.

FOR NHS USE ONLY

Actioned by practice yes/no

Date .....

Ref: 4705

## NHS England's Care.Data – Opt-Out Form

NHS England's care.data system aims to provide timely, accurate information to citizens, clinicians and commissioners about the treatments and care provided by the NHS.

Please refer to the NHS England's care.data patient information leaflet before completing this form. The NHS England's care.data patient information leaflet can be found on the NHS Choices website ([www.nhs.uk](http://www.nhs.uk)).

### OPT-OUT FORM – Confidential

|    |  |                          |
|----|--|--------------------------|
| A. | Please tick this box if you do not want your GP to release any of your GP record to the Health and Social Care Information Centre for purposes of the care.data system. (9Nu0)   | <input type="checkbox"/> |
| B. | Please tick this box if you do not want the Health and Social Care Information Centre to disclose to any accredited third parties any information they hold on you (from any NHS source). Please note that, in general, such data would only be made available to accredited third parties in anonymised, pseudonymised or aggregated form. (9Nu4) | <input type="checkbox"/> |
| C. | <p>Please complete in BLOCK CAPITALS</p> <p>Title: _____ Surname / Family Name: _____</p> <p>Forename: _____ Date of Birth _____</p> <p>Address: _____</p> <p>Postcode: _____ Phone No: _____</p> <p>Signature: _____ Date: _____</p>  |                          |
| D. | <p>If you are filling out this form on behalf of another person or a child, their registered GP will consider this request. Please ensure that you fill out their details in section C and your details in section D.</p> <p>Your Name: _____</p> <p>Your Signature: _____</p> <p>Relationship to Patient: _____ Date: _____</p>                   |                          |

### FOR PRACTICE USE ONLY:

Patient record updated with Read Code 9Nu0 "Dissent from secondary use of GP patient identifiable data and Read Code 9Nu4 "Dissent from disclosure of personal confidential data by Health and Social Care Information Centre"

Date completed: \_\_\_\_\_ Initials \_\_\_\_\_

## CHECK LIST WHEN REGISTERING

(Tick)

- Catchment Area** – please check that you are within our boundary by going to our website [www.deepingspractice.co.uk](http://www.deepingspractice.co.uk) and clicking on the New Patient tab. By putting in your postcode a message will be displayed which will inform you if you are within in our boundary.
  
- Photographic ID** – Please bring photographic ID to show at reception such as:
  - Passport
  - Driving Licence(only 16 years of age and over)
  
- Proof of address** – please provide proof of address. This must contain both your new address and your name. Suitable documents are:
  - Council Tax form
  - Solicitors letter
  - Bank Statement(only 16 years of age and over)
  
- GS1 form** – please sign at the base of the form.
  
- SMS Text Messaging** - If you would like to receive a text message reminding you of an appointment you have booked, please fill in the SMS consent form.
  
- Online patient access** – If you would like to book an appointment or order repeat prescriptions online please fill in the Online Access form.
  
- Summary Care Record Opt-Out form** – If you would like to opt-out of sharing your record please fill in the Opt-out form. (Please read the enclosed information paperwork).
  
- Care.Data Opt-Out form** – If you would like to opt-out please fill in the enclosed Opt-Out form. (Please read the enclosed information paperwork).