# NHS Family doctor services registration GM51

## 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_______/_________/_________

### 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:

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

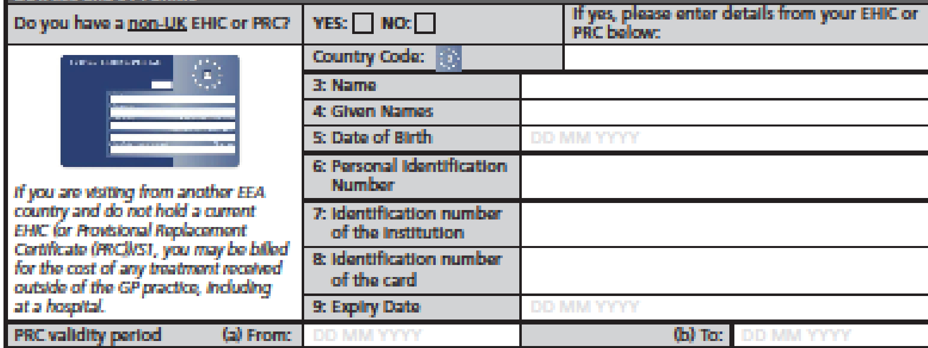
I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

**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: ☐ 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 | |
| *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.* | 9: Expiry Date | DD MM YYYY |
| PRC validity period (a) From: | DD MM YYYY | (b) To: 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.

THE DEEPINGS practice

# NEW PATIENT REGISTRATION FORM

**Title:** Mr ☐ Mrs ☐ Ms ☐ Miss ☐
Master ☐ Other ______________________
*(Please tick)*

**DOB:** **Age:**

**How many adults in the household: ………………**
**How many children in the household: …………..**

**NHS NO:**

**Surname:** ________________________________________

**First Name:** ________________________________________

**Middle Name(s):** ________________________________

**Previous / Surname:** ______________________________

**Marital Status:** Single ☐ Married ☐ Co-habiting ☐ Widowed ☐ Separated ☐ Divorced ☐

**Town of Birth:** **Country of Birth:**

**Contact Details**: **Home:**
**Mobile:** **Work:**

**Address:**

**Postcode:**

**Email:**

**Previous address:**

**Postcode:**

**Previous Doctors:**

**Postcode:**

**NEXT OF KIN / EMERGENCY CONTACT DETAILS:**

**Name:** ________________________________ **Relationship:** ____________________

**Address:** ______________________________________________________________

______________________________________________________________________

**Postcode:** ______________________________ **Telephone:** ______________________________

**Is this person your carer:** **YES** ☐ **NO** ☐ **If YES is this your main carer:** **YES** ☐ **NO** ☐

***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***

**FOR OFFICE USE**

**Proof of Identification seen:** ☐ **Type of document seen:** ______________________________

**Proof of residency seen:** ☐ **Type of document seen:** ______________________________

**Checked by:** ______________________________ **Date checked:** ______________________________

**Registered with Dr** ______________________________ **Date of Registration:** ______________________

# 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)

..............................................................................................................

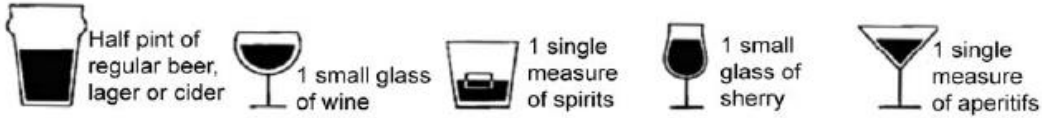
**E: Chinese or other ethnic group**

- ☐ 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 | |

| **Scoring**: 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 | **Score** |
|---|---|

| 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 | |

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

**Smoking Status**

Please tick the entry which best describes your smoking status:

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

Number of Grams: ________

Would you like Smoking advice? YES / NO

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 Glinton 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 13th 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 16th 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 (If patient is under 13 use Parent/Guardian mobile number): | |
| Email Address of patient (Must be a unique Email address for this patient – shared Email **NOT** allowed) | |
| Mobile Number (If patient is under 13 use Parent/Guardian mobile number): | |

Login Details:

**New Registration patient** – login details will be sent to the Registered Address

**Current patient** – login details will be Emailed to the Registered Email

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

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For Office use:
Patient Record Update by: Date:

THE DEEPINGS practice

# 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.

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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: ______________

<u>Disclaimer</u>

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.

---

For Office use:

Patient Record Update by: Date:

NHS Digital

# 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 who 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.

- **Express consent for medication, allergies and adverse reactions only.** You wish to share information about medication, allergies for adverse reactions only.
- **Express consent for medication, allergies, adverse reactions and additional information.** You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your 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.
- **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.

If you chose not to complete this consent form, a core Summary Care Record (SCR) **will** be created for you, which will contain only medications, allergies and adverse reactions.

Once you have completed the consent form, please return it to your GP practice.

You are free to change your decision at any time by informing your GP practice.

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NHS Digital

# 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: ______________________________________________

Date of birth: ____________________________ Patient's postcode: _____________________

Surgery name: ____________________________ Surgery location (Town): _________________

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 |
|---|---|---|

For more information, please visit https://www.digital.nhs.uk/summary-care-records/patients, call NHS Digital on 0300 303 5678 or speak to your GP Practice.

**For GP practice use only**

To update the patient's consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.

| Summary Care Record consent preference | Read 2 | CTV3 |
|---|---|---|
| The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only) | 9Ndm | XaXbY |
| The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information) | 9Ndn | XaXbZ |
| The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out) | 9Ndo | XaXj6 |

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THE DEEPINGS practice

# 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).

**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) | ☐ |
| 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) | ☐ |
| C. | Please complete in BLOCK CAPITALS<br><br>Title: __________ Surname / Family Name: ______________________<br><br>Forename: ______________________ Date of Birth ______________<br><br>Address: ________________________________________<br><br>Postcode: ____________________ Phone No: ____________________<br><br>Signature: ____________________ Date: ____________________ | |
| D. | 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.<br><br>Your Name: ________________________________________<br><br>Your Signature: ________________________________________<br><br>Relationship to Patient: ____________________ Date: ______________ | |

**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 ____________________

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THE DEEPINGS practice

# CHECK LIST WHEN REGISTERING

(Tick)

☐ **Catchment Area** – please check that you are within our boundary by going to our website 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).

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