Practice Name

New Patient Registration Form (Adult: 16 and over)

Today's Date

Instructions for completing this form

1. Complete a separate form for each family member to be registered
2. Complete in BLOCK CAPITALS and tick the boxes as appropriate
3. PLEASE FILL OUT ALL the registration form. Otherwise, the registration will not be able to be processed.

1

Full Name:				**Telephone Number:**
Title : **Mr** ☐	**Mrs** ☐	**Miss** ☐	**Ms** ☐	**Work tel. number:**
Other. *Please state* **:**				**Mobile tel. number:**
Address:				We will use this to send appointment reminders and health promotion details. Please tick here if you do not wish to receive text messages from us: ☐
				Next of Kin: **Relationship to Patient:**
Postcode:				**Next of Kin contact tel. number:**
E-mail address:				**Maiden name / Mothers name if different:**
				Marital Status:
How would you prefer us to contact you: **Letter** ☐ **Email** ☐ **SMS (text)** ☐ **Phone** ☐			**Date of Birth:**	**Gender:** **Male** ☐ **Female** ☐ **Indeterminate** ☐
Town* and Country of birth **(*If town is London please state which Borough)**		**Country:** **Town:**		**Borough (*If born in London):**
Please list other residents of your home who are registered with us:	**Name:**			**Date of Birth:**

2

Looking After A Family Member

Are you looking after someone? Let us know if you are looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems.	Yes ☐ No ☐
Is someone looking after you? Let us know if a family member, friend or neighbour looks after you. If yes, they are your carer. You are welcome to invite your carer to accompany you to visits at the practice.	Yes ☐ No ☐

Carer's name :	**Relationship to you:**
Address of carer :	
Telephone number of carer **:**	

3	**Are You Currently Employed?**			
	If so please specify whether :	**Full-time** ☐	**Part-time** ☐	**Self-employed** ☐
	If you are not employed, please indicate which best describes you:			
	Retired ☐	**Student** ☐	**Housewife/ Homemaker/House husband** ☐	**Unemployed** ☐
	Other ☐ ***Please state***:			
	If returning from the Armed Forces please state which below: • **Army** ☐ • **Royal Navy** ☐ • **Royal Air force** ☐		**Comments:**	

4	**Your Religion** (Please tick)					
	C of E ☐	Catholic ☐	Other Christian (state): ☐	Buddhist ☐	Hindu ☐	Muslim ☐
	Sikh ☐	Jewish ☐	Jehovah's Witness ☐	No religion ☐	Other religion (state) ☐	
a	**Your Ethnic Origin** (Please tick one)					
	Black Caribbean/British ☐	Indian / British Indian ☐	Arabic ☐	White (UK) ☐		
	Black African /British ☐	Pakistani / British Pakistani ☐	Chinese ☐	White (Irish) ☐		
	Other Black Background ☐	Bangladeshi / British Bangladeshi ☐	Other ☐	White (Other) ☐		
	Other Mixed Background ☐	Other Asian Background ☐		Ethnic Category Refused: ☐		
b	**Main Spoken Language?**		**Do you need an interpreter?** Yes ☐	No ☐		
c	**Do you need help with mobility/hearing/speaking?** (tick all that apply)					
	Wheelchair ☐	Walking aid ☐	Hearing aid ☐	British sign language (BSL) ☐	Makaton sign language ☐	
	Lip reading: ☐	Large print: ☐	Braille ☐	Other. ***Please state***: ☐		
d	**Are you currently?**	Homeless ☐	A Refugee ☐	An Asylum Seeker ☐		
	Are you an 'Assistance Dog' User?	Yes ☐	No ☐			
	Are you housebound?	Yes ☐	No ☐			

5	**Women Only**	What is the date of your last ***Smear test***?	Date:	Result:
	Was this at your GP Surgery?	Yes ☐ No ☐	Date of last ***Mammogram*** (if applicable):	
	Number of ***pregnancies*** (include miscarriages & terminations) (If applicable)			
	Do you wish to see a doctor in this Practice for contraceptive services (including the pill, coil or cap)?			Yes ☐ No ☐

6 Your Medical Background

Are there any serious diseases that affect your parents, brothers or sisters?
Tick all that apply *and* state family member:

Diabetes ☐ Who:	Asthma ☐ Who:	Thyroid disorder ☐ Who:	Stroke ☐ Who:	COPD ☐ Who:
Heart Attack ☐ under age of 60 Who:	Cancer (Specify type) ☐ Who:	High Blood pressure ☐ Who:	Any other important family illness. *Please state*:	Who:

Please state any allergies and sensitivities you have to medicines, food & dressings:	
Please state any mental disabilities you have:	

Are you able to administer your own medicines?	Yes ☐ No ☐	***If no*** please give details, e.g. swallowing or opening containers:

What chronic medical conditions have you had?	Date of Diagnosis:
What operations have you had?	Date of operation/s:
What injuries have you had?	Date of injury/s

Please list any tablets, medicines or other treatments you are currently taking / undertaking:

7 Lifestyle

Are you currently a smoker?	☐ Yes	☐ No	If you smoke, how many Cigarettes / Cigars / Tobacco do you smoke in a week?
Have you ever been a smoker?	☐ Yes	☐ No	

If you are a smoker and want to STOP please tick here: ☐

8	Diet and Exercise			What type of diet do you have?	
	How much exercise do you do?			Healthy	☐
	Sedentary	(No exercise)	☐	Unhealthy	☐
	Gentle	(climbs stairs, walking , gardening)	☐	Vegan	☐
	Moderate	(Cycling, swimming regularly)	☐	Vegetarian	☐
	Vigorous	(Attends gym regularly)	☐	Moderate	☐

Please enter your height in		Please enter your weight in	
Feet / inches:	**cm:**	**Kilos/grams:**	**Stones / lbs:**

9	Sharing Your Medical Record
	Medical Record Sharing allows your complete GP medical record to be made available to authorised healthcare professionals involved in your care. You will always be asked your permission before anybody looks at your shared medical record. **If you don't want to share your GP record tick here: :** ☐
	Summary Care Record contains details of your key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. You will always be asked your permission before anybody looks at your Summary Care Record. **If you don't want to have a Summary Care Record tick here:** ☐
	The Care.data Programme Collates information about you and the care you receive. It links information from all the different places where you receive care, such as your GP, hospital and community services, to help them provide a full picture of your medical needs and the care you are receiving. This data is made available to NHS Commissioners so that they can design integrated services and is shared with third parties for research purposes. **I wish to OPT OUT from my Personal Confidential Data being shared outside my *GP practice*:** ☐ **I wish to OPT OUT from my Personal Confidential Data being shared with *third parties*:** ☐

10	Patient Participation Group (PPG)	
	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 • By expressing your interest, you will be helping us to plan ways of involving patients that suit you • It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice • If you are interested in getting involved in the PPG, please tick yes in the box below and we will arrange for the Practice for the Practice Patient Participation Group Application Form to be given to you at your initial consultation	
	Yes I am interested in becoming involved in the PPG ☐	***No*** I am not interested in becoming involved in the PPG ☐

11	Other Information		
	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 first appointment.
	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:	

12	Signature	
	Patient signature:	Signature on behalf of patient:

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	
TOTAL						

Scoring:
A total of 5+ is AUDIT-C positive, and indicates higher risk of drinking

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	
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	
TOTAL						

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependency

PHQ9 and GAD7

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed, or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
				PHQ9 total score	☐

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
				GAD7 total score	☐

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: Discharge date: (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

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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.