



New Patient Registration

Please also ensure you fill in the purple GMS 1 form

Title Mr/Mrs/Miss/Ms/Dr

Surname _____

First Name _____

Middle Names _____

Address _____

Postcode _____

Date of Birth ____ / ____ / ____

Your ethnic group _____

Tick the box if you prefer not to state your ethnic group

Your first language _____

E-mail address _____

Home Telephone _____

Mobile Telephone _____

We may wish to send SMS text messages to your mobile phone to send information such as appointment reminders, if you are happy for us to do this, please tick this box

Occupation _____

If you have any known allergies please provide details below:



If you are a carer for another patient registered at this surgery, please tick the box and ask at reception for a carer form

Smoking Status

- I have never smoked
- I used to smoke but don't now
- I currently smoke

The practice runs smoking cessation clinics, if you would like help giving up and would like the practice to contact you to arrange an appointment for this, please tick this box

Alcohol Consumption

Do you consume alcohol? Yes No

If so, how many units a week do you consume _____

Repeat Medication

If you are currently taking any repeat medication, please attach a copy of your latest repeat slip from your last GP, or a list of medication you currently take if you don't have one.

*If you **do not** take any repeat medication, please tick here*

Dispensary

We offer an in-house service to dispense medication to patients who live outside of Spalding and more than 1 mile from a community pharmacy. This means you would be able to collect your medication from the surgery. Would you like to use this service if you are eligible?

Yes No

Thank you for completing this form

Please hand it to Reception, along with the purple form and any additional information requested

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
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If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number	Enlistment date
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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 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

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:

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