NEW PATIENT REGISTRATION CHECKLIST

Please check that the Registration Form is fully completed and signed and all the relevant documents are attached. If there is anything missing we will be unable to register you.

		Tick box
1.	Registration Form fully completed – including all contact numbers	☐
2.	Registration Form signed and dated	☐
3.	**Photo ID i.e. Passport/Driving Licence**	☐
4.	**Proof of address i.e. utility bill/bank statement**	☐
5.	New Patient Health Questionnaire	☐
6.	Ethnic Origin Form / Patient Declaration	☐
7.	Blood Pressure Form **(if over 179/119, please see nurse)**	☐
8.	Third party Consent Form	☐
9.	Patient Opt Out Form	☐
10.	Electronic Consent and Online Registration Form	☐
11.	General Data Protection Regulation – Adult - ***(patient to keep)***	
12.	GP Allocated • ***Please note that the GP with whom you are registered may change. We will not always notify you of this change***	☐
13.	Copy of Repeat Prescription / Medication details ***(not handwritten)***	☐

We require that new patients provide evidence of their full name, date of birth and their address when they register with the Sid Valley Practice.

We are able to accept the following documents for this purpose:

1. Passport, birth certificate or British driving licence
2. Documentary proof of your present address including postcode (such as utility bill or bank statement)

Unfortunately we will be unable to register you without these details.

For staff use only:

Name of Patient: ....

Patient's Date of Birth: ....

Registration pack received by (Staff member): ....

Date received: ....

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: DD MM YY Discharge date: DD MM YY (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*

☐ 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

**Not all doctors are authorised to dispense medicines*

☐ Signature of Patient ☐ Signature on behalf of patient

Date____/____/____

What is your ethnic group?

Please tick one box that best describes your ethnic group or background from the options below:

White: ☐ British ☐ Irish ☐ Irish Traveller ☐ Traveller ☐ Gypsy/Romany ☐ Polish
☐ Any other white background (please write in):

Mixed: ☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian
☐ Any other Mixed background (please write in):

Asian or Asian British: ☐ Indian ☐ Pakistani ☐ Bangladeshi
☐ Any other Asian background (please write in):

Black or Black British: ☐ Caribbean ☐ African ☐ Somali ☐ Nigerian
☐ Any other Black background (please write in):

Other ethnic group: ☐ Chinese ☐ Filipino
☐ Any other ethnic group (please write in):

Not stated: ☐
Not Stated should be used where the PERSON has been given the opportunity to state their ETHNIC CATEGORY but chose not to.

NHS England use only Patient registered for ☐ GMS ☐ Dispensing

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 – 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 an EU 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	
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.	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

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 Business Service Authority for the purpose of recovering your NHS costs from your home country.

Please complete this Questionnaire to help us record useful data on your medical records. All this information is kept confidentially. If you have anyone in your household who has not attended the Health Centre for some time, perhaps you could take extra copies for them to complete.

FULL NAME	**DATE OF BIRTH**	**OCCUPATION (or previous if retired)**

Next of Kin: First name ....**Surname** ....

Relationship to you: ....

Contact details: Mobile no .... **Landline no:** ....

ALCOHOL CONSUMPTION

I currently drink ....units per week	I am a lifelong teetotaler	I am an ex-drinker ....

(One unit of alcohol = ½ pint beer or 1 small glass of wine or 1 spirit measure)

SMOKING - Do you smoke? YES/NO   Have you ever smoked? YES/NO

What and how many do you, or did you smoke?

.... Cigarettes per day (average)	.... Cigars per day (average)	.... Tobacco ounces per day (average)

Number of years smoked? ....   If ex-smoker – year you gave up: ....

If you smoke we can help you give up. We can offer Nicotine Replacement Therapy medication on prescription and/or help and advice from the One Small Step organization. Please ring One Small Step on 0800 298 2654 or visit their website onesmallstep.org.uk

ALLERGIES – Do you have any allergies – if so please give details: ....

What reactions do you have with this allergy? ....

EXERCISE - Which correctly describes your exercise regime?

Exercise physically impossible	Enjoy light exercise	Enjoy moderate exercise	Enjoy heavy exercise
Aerobic exercise 1 times/week	Aerobic exercise 2 times/week	Aerobic exercise 3 times/week	Aerobic exercise more than 3 times/week

DIET - Which of the following most closely describes your diet?

Diet Good	Diet Poor	Diet Average	High Fibre Diet
Vegan/Strict Vegetarian	Diet Low in Fat	Diabetic Diet	Weight Reducing Diet

FAMILY HISTORY – Please tick box if first degree relatives i.e. father, mother, brother or sister has a history of:-

Diabetes	High Blood Pressure	Heart Attack/Angina Under 60	Heart Attack/Angina Over 60
Asthma	Bowel Cancer	Breast Cancer	Prostate Cancer
Ovarian Cancer	Stroke	Glaucoma	Epilepsy

CHEMIST – Please indicate which Chemist you would like your prescriptions to be sent to

BOOTS FORE ST	WOOLBROOK BOOTS	LLOYDS HIGH ST	LLOYDS STOWFORD

PATIENT REGISTRATION DECLARATION

(To be competed in addition to Family Doctor Services Registration form GMS1)

In order to register with a Family Doctor please answer the following questions IF you have been living outside of the UK in the last 12 months.

Where have you lived for the last 12 months?

....

If previous resident of UK – date you left the country

....

Date you returned/entered the UK?

....

What is the basis for your stay in the UK?

....

Are you planning to remain in the UK permanently?

....

If No, state the length of time you plan to remain in UK

....

Can you show that you have the right to live here?
(ie. Passport, visa a letter from the Home Office)

....

Your Full Name:

....

Date of Birth: ....

Signature: ....

Sid Valley Practice

Partners
Dr Mike Slot
Dr Ross Dell
Dr Sara Hadfield
Dr Andrew Rosewarne
Dr Joe Stych
Dr Jane Coop

Associate GP
Dr Katie Phillips
Dr Sarah Hannabuss
Dr Felicity Knott
Dr Jemima Ewart
Dr Heloise Moore-Mate
Dr Briony Tebbutt

Salaried GP
Dr Sally Dutson

Practice Manager
Mr Andy Hosking

Patient's Full Name ....

Patient's Date of Birth ....

Patient's NHS Number ....

CONSENT

I ,AUTHORISE my General Practitioner to release information regarding my medical condition to the person/people listed below:

(Full Name in block capitals) ....

Relationship to the patient ....

Telephone number/s..

For the next .... months ☐ 6 months ☐ 1 year ☐ indefinitely ☐

(please tick as appropriate)

Patient's Signature .... **Date** ....

Office Use only:

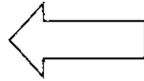
Authorisation recorded by ....

Date ....

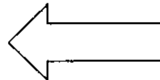
Blood Pressure

Please provide us with your current blood pressure readings and current weight so that we can ensure correct monitoring of your health care. If you smoke, please be so kind as to inform us!

Blood Pressure machines are available for you to use at The Beacon Medical Centre and Blackmore Health Centre.



Please staple your blood pressure result slip to this form, complete your details below, and hand to reception



Please enter your weight.

First name	
Surname	
Date of Birth	

Please help us to update your smoking status			
Do you smoke?	Yes/No	Have you ever smoked?	Yes/No
If yes how many do you/did you smoke?			
Cigarettes per day..................	Cigars per day.................	Grams Tobacco per day...........	
Number of years smoked......	If ex-smoker year you started...........	Year you gave up...........	

If you smoke we can help you give up. We can offer Nicotine Replacement Therapy medication on prescription and/or help and advice from the ***One Small Step*** *organization. Please ring* ***One Small Step*** *on* ***0800 298 2654*** *or visit their website onesmallstep.org.uk.*

PLEASE COMPLETE SECTIONS 1, 2 and 3
COMPLETE SECTION 4 BY PLACING A CROSS ('X') IF YOU WISH TO OPT OUT OF THE SUMMARY OR LOCAL HEALTH RECORDS

1. Patient Name (Print) ……………………………………………..
2. Patient Signature ………………………………………………....

3. Date of Birth……………………………………………………

Section 4

SUMMARY CARE RECORD – This is a summary of your **Medication, Allergies & Adverse Reactions &** can only be accessed by a **Clinician in England &** with your **expressed consent**. This will help with your care. Web site is – htpps://digital.nhs.uk/summary-care-records/patients	
SUMMARY CARE RECORD – with **Additional information.** This will include, **Problems, Reasons for Medication, Significant Procedures, Immunisations, Height, Weight & Blood Pressure. Associated free text from included clinical codes;** & can only be accessed by a **Clinician in England &** with your **expressed consent**. This will help with your care.	
LOCAL HEALTH RECORD- This allows access to your **FULL** Health record to **Out of Hours Service & Secondary Care Clinicians in Devon Only,** & with your **Express Consent** at point of care. This will help with your care. **Leaflets & Posters are available in the Practice.**	

YOU HAVE A CHOICE

You have a 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.

The Sid Valley Practice

www.sidvalleypractice.nhs.uk

Application for online services, SMS text and Email
You can opt for any or all of the services list below

Surname	Date of Birth
First Name	
Address (Including Postcode)	
Email Address	
Telephone Number	Mobile Number

PART ONE

I consent to receiving text messages from Sid Valley Practice for the purposes of health promotion, Practice news and appointment reminders, PPG events and information, Surveys	YES / NO
I consent to receive email messages from Sid Valley Practice for the purposes of health promotion, Practice news and appointment reminders, PPG events and information, Surveys	YES / NO

If you do not wish to register for online services as below, please go to page 2 to complete declaration.

PART TWO

Application for online access to my medical records

To access online services patients must present with two separate types of identification, one of which must be photo ID.

I wish to have access to the following online services (please tick all that apply)

1. Booking Appointments with your own GP	
2. Requesting Repeat Medications	
3. Accessing My Medical Records – Please allow up to 28 working days for this process to be completed	

Your application is not complete unless you have read, ticked and signed the declarations on Page 2. Please continue on to the page overleaf.

DECLARATION

I wish to access my medical records online and understand and agree with each statement below (please tick)

	TEXT	EMAIL	ONLINE SERVICES
I have read and understood the information in the Practice Booklet under the section Text, Email and Online Services provided by Sid Valley Practice			
I acknowledge that appointment reminders by text are an additional service and that they may not be sent on all occasions but that the responsibility for attending or cancelling appointments still rests with me.			
Text messages are generated using a secure facility but I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. However, the Sid Valley Practice will not transmit any information which would enable an individual patient to be identified			
I understand that it is my responsibility to inform the Sid Valley Practice if I change my phone numbers or email address or no longer have access to either or both			
I will be responsible for the security of the information that I see or download			
If I choose to share my information with anyone else, that is at my own risk			
I will contact the Sid Valley Practice as soon as possible if I suspect that my account has been accessed by someone without my agreement			
If I see information in my record that is not about me or is inaccurate, I will contact the Sid Valley Practice as soon as possible.			

You can withdraw or change your consent at any time by completing and sending in a new form

Signature:	Date:

For staff use:

Patient NHS Number:		
Identity Verified by:	Date:	Please tick Photo ID and proof of Residence photocopied
Authorised by:	Date:	Date Account Created:

Send for Scanning