Registering as a patient at Kingswood Surgery

We are very pleased that you would like to register as a patient at Kingswood Surgery. Please complete the attached registration form and Patient Health Questionnaire. If you want to register your children a separate form and Questionnaire must be completed for each child. Proof of identity and proof of address will be required for each prospective patient. We will be unable to register you without seeing the original documentation required. Copies are not accepted.

PLEASE NOTE: ONLY ORIGINAL DOCUMENTS WILL BE

FOR OFFICE USE ONLY

Previous Doctor's details provided (if applicable)	
NHS Number (if available)	
FOR UK NATIONALS: You will need	**CHECK LIST**
1) GMS1 Form: **Valid Passport** or **Driving Licence (photo)** **2) 2 X Proofs of Address:** Utility Bill, Council Tax or Bank Statement Please note: A Mobile phone bill is unacceptable.	What presented?
FOR PATIENTS FROM THE EU: You will need:	**CHECK LIST**
1) GMS1 Form: You must include the date you first came to the UK. **2) Valid Passport** **3) 2 x Proofs of Address:** Utility Bill, Council Tax or Bank Statement	What presented?
FOR PATIENTS FROM NON-EU COUNTRIES: You will need:	**CHECK LIST**
1) GMS1 Form: You must include the date you first came to the UK. **2) Valid Passport** **3) Valid Visa** **4) 2 x Proofs of Address:** Utility Bill, Council Tax or Bank Statement **Your Visa details will be noted and you will have to represent valid documents after expiry.**	What presented?
NB: The possession of an NHS number does not necessarily mean you are entitled to all NHS Services. **If required, I agree to provide further information. Failure to provide this information could delay my registration.** Patient Signature Date	**GMS1 SIGNED & DATED** Seen by:

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 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_____/_____/_____

Version 01/02

Please see overleaf re: Organ donation

NHS Family doctor services registration

GMS1

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:

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

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice

Drs Berry, Verges, Walton, Ahmed, Choedon & Anzak

Kingswood Surgery, Hollis Road, High Wycombe, Buckinghamshire. HP13 7UN

New Patient Health Questionnaire (Confidential)

Please PRINT your answers clearly, using BLACK ink.

Date of Birth: **dd.mmm.yyyy**					Gender: **Male / Female**
Title: **Mr / Mrs / Ms / Miss / Master / Dr / Rev / Other:**					
Surname					
Forenames:					
Address:					
Postcode:					
Telephone Numbers: (Please tell us about any changes when they happen)					
Home		**Work**		**Mobile**	
E-mail:					
Preferred Contact Method: Email: Y/N Post : Y/N Telephone: Y/N					
Next of kin details:					
Relationship:					
Title: **Mr / Mrs / Ms / Miss / Master / Dr / Rev / Other:**					
Surname					
Forenames:					
Telephone Numbers: (Please tell us about any changes when they happen)					
Home		**Work**		**Mobile**	
Children aged 16 and under – **Name of school:**					
Marital status:	**Single / Married / Separated / Widowed / Divorced / Cohabiting**				
Weight:		Height:			
What is your ethnic group? This information is required for government health planning. Please tick / circle the appropriate group.					
British	Irish	Any other white (please write in)			
White and Black Caribbean		White and Black African		White and Asian	
Any other mixed (please write in)					
Indian	Pakistani	Bangladeshi	Any other Asian (please write in)		
Caribbean	African	Any other Black (please write in)			
Chinese	Any other (please write in)			Not Stated	
What language do you speak?					
Do you use an interpreter?	**Yes / No**				
General Health					

Do you exercise regularly each week?	Yes / No		
Do you smoke?	Never smoked	Stopped smoking	Current smoker
Smokers, what do you smoke?	Cigarettes	Cigars	Pipe or roll-ups
Number of quantity of tobacco	/ day	/ day	Grams / week
Do you drink alcohol? 1 unit = ½ pt beer, 125ml glass wine, 1 pub measure spirits.	Yes / No	Units / week	

Women Only

Are you using any form of contraception?	Yes / No	Details	
Have you ever had a cervical smear?	Yes / No	Date of last	
Have you ever had a mammogram(breast x-ray)?	Yes / No	Date of last	
Have you had rubella (German measles)?	Yes / No	Rubella vaccination?	Yes / No
Have you had a rubella blood test?	Yes / No	If so are you immune?	Yes / No

Medical History

Have you ever had, or received treatment for, any of the following conditions?

Thrombosis (blood clot)	Y	N	Glaucoma	Y	N	Asthma	Y	N
Tuberculosis	Y	N	High blood pressure	Y	N	Stomach ulcer	Y	N
Cancer	Y	N	Heart attack / disease	Y	N	Epilepsy / Convulsions	Y	N
Diabetes	Y	N	Angina	Y	N	Jaundice	Y	N
Rheumatic fever	Y	N	Stroke	Y	N	Depression	Y	N

Have you ever had any other serious illness, injury or operation?	Y	N
If yes, please give details, including approximate dates:		

Medication

Do you take any medicines, including the contraceptive pill?	Y	N
If yes, please attach your repeat list from your previous surgery and /or give details below		

Medicine (name and strength)	What dose do you take?	How often do you take this medicine?	How long have you been taking this medicine?

Have you had any allergies to any medicines?	Y	N
If yes, please give details including what sort of reaction you have had		
Do you have any other allergies, e.g. peanuts, strawberries?	Y	N
If yes, please give details		
Do you take any other medicines or dietary supplements?	Y	N
If yes, please give details		

Family History

Is there a family history of any of the following conditions? If so, please state which family member has the condition, e.g. mother, father, brother sister, uncle, aunt, grandmother or grandfather on mother's side (maternal), grandmother or grandfather on father's side (paternal).

Condition			**Family member**	**Condition**			**Family member**
Heart attack/disease				Breast cancer	Y	N	
Under 60	Y	N		Ovarian cancer	Y	N	
Over 60	Y	N		Prostrate cancer	Y	N	
Stroke	Y	N		Bowel cancer	Y	N	
High blood pressure	Y	N		Other inherited	Y	N	
Diabetes	Y	N		Please write in			

Donors

Are you a registered organ donor?	Y	N
Do you donate blood?	Y	N

Carers

Are you a carer, do you look after someone who is mentally or physically disabled or ill, or elderly or frail? If yes, please give details.	Y	N
Do you have a carer? If yes please give details below	Y	N

Consent to Access Medical Records

This practice holds medical records relating to the treatment and services patients receive from their GP. We are asking permission for these records to be looked at by external auditors assessing quality of care if the need should arise.

Your GP practice supports these checks, as they are an important part of ensuring quality and efficiency of care and treatment in the NHS. The auditors who carry out these checks are bound by the strict rules of confidentiality and your records will only be used for the purpose described.

Please tick either of the two boxes below:

	I DO consent to auditors looking at my medical records
	I DO NOT consent to auditors looking at my medical records

Summary Care Records – your emergency care summary

The summary care record (SCR) will contain information about any medicines you are taking, allergies you suffer from and any allergic reactions you have had. It will be used in emergency care (A&E, Out of Hours, Walk-in centres, and Temporary patients at other practices), to ensure those caring for you have enough information to treat you safely. If you already have an SCR, or are happy to have one, you do not need to take any action. If you do not want an SCR, please check the "no" box below and we will arrange for you to opt out of the SCR scheme. If you need more information, please ask at the Surgery. Please tick the box below **only** if you would like to **opt out** of the Summary care record:

	No I do not want a Summary Care Record

Full Name:_____ Date of Birth:_____

Signature:_____ Date:_____