THE NEW MILL STREET SURGERY

NEW PATIENT REGISTRATION FORM (GMS1) FOR UNDER 16

Please fill in this form fully including details of your previous doctor and bring it to the practice. Patients under 16 can only be registered with the practice if their parent or guardian is currently registered. All registrations are dealt with after 11am and take 48 hours to process.

For all Patients under 6 evidence of all vaccinations given either in the UK or abroad must be provided. Failure to complete this information will result in registration at the practice being declined. We are looking forward to registering you. If writing is not legible this may delay the registration.

1 PATIENT DETAILS

Please complete in BLOCK CAPTIALS IN BLACK INK and tick where appropriate

Title Mr ☐ Mrs ☐ Miss ☐ Other ☐ Gender Male ☐ Female ☐ Other: ☐

Surname ____ First name(s) ____

Previous surname (Maiden name) ____ Date of birth ____

Home address ____

Place of birth ____ Postcode ____

Home phone ____ Mobile phone ____

Email address ____ NHS number / /

Next of kin ____ Relationship ____ Contact number ____

Please provide details for any else who is involved in the provision of the care for your child, for example social worker. Please provide their name, contact details and borough they work in.

Please tell us if there is anyone who has a relationship with your child that you do **not** wish to have access to your child's medical records. Please fill in the details in the section below so we are aware should this person tried to contact the practice at any time.

2 PREVIOUS MEDICAL RECORDS

Please help us trace your previous medical records by providing ALL the following information

Your previous address in the UK ____

Name and address of previous doctor while at that address ____

If you are from abroad - Your first UK address where registereed with a GP ____

If previously resident of the UK, date of leaving D D / M M / Y Y Y Y Date you first came to live in the UK D D / M M / Y Y Y Y

If you are returning from the Armed Forces - Address before enlisting ____

Enlistment date ____ Service or Personnel number ____

3 PATIENT PROFILE

What is your national identity? [ ] What is your main spoken language? [ ]

What language do you read? [ ] I can read English Yes [ ] No [ ] Interpreter or Translator required [ ]

Do you need large print? Yes [ ] No [ ] Do you use lip reading? Yes [ ] No [ ] Do you use Makaton? Yes [ ] No [ ]

Do you use Textphone/ Minicom? Yes [ ] No [ ] Do you rely on British Sign Language? Yes [ ] No [ ]

Someone helped me to fill in this form as I do not read any language Yes [ ] No [ ]

What is your religion? [ ]

Some ethnic groups may be more at risk of some diseases. It will help us if you tell us your ethnic group.

A - Asian or Asian British

Bangladeshi [ ] Indian [ ] Pakistani [ ]

Other [ ]

B - Black or Black British

African [ ] Caribbean [ ] Other [ ]

C - Chinese or Other Ethnic Groups

Chinese [ ]

D - Mixed Background

White & Asian [ ] White & Black African [ ] White & Black Caribbean [ ] Other [ ]

E - White

British [ ] Irish [ ] Other [ ]

Any other ethnic group [ ]

4 NHS ORGAN AND BLOOD DONOR REGISTRATION

I wish 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 [ ]

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

Signature [ ] Date DD / MM / YYYY

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood. Thick here if you have given blood in the last 3 years [ ]

For more information, please ask at reception for an information leaflet on joning the NHS Blood Donor Register

Signature [ ] Date DD / MM / YYYY

NHS USE ONLY
Actioned by practice
Yes [ ] No [ ]
Date DD / MM / YYYY

5 DECLARATION

Please note we can fully register children under 6 only when we have seen their full vaccination records. Please bring with you your Red Book or any other national documentation you may have. It is important for your health and a legal requirement that the information you have given is correct.

I have answered the questions in this form to my best ability - Signature

[ ] Signature of Patient

[ ] Signature on behalf of Patient

Date DD / MM / YYYY

6 PAST MEDICAL HISTORY

Have you ever had any surgery? Yes ☐ No ☐ Date DD / MM / YYYY

Details

Have you got any medical conditions? Yes ☐ No ☐ **Height:** cm **Weight:** Kg

Details

7 MEDICATION

Are you taking any medication currently including contraceptive pills? Yes ☐ No ☐

Details (i.e. drug name & dose)

8 SMOKING

Do you smoke? Yes ☐ No ☐ If yes, how many per day? ☐ If no, when did you stop? DD / MM / YYY

9 ALLERGIES

Are you allergic to any medicines or foods? Yes ☐ No ☐ If so, please name

10 CHILDHOOD PRIMARY VACCINATION SCHEDULE (UNDER 6)

Vaccine	Protection against	Age	Fill in dates
5 in 1 vaccine	Diphtheria, tetanus, whooping cough, polio and Hib (Haemophilus influenzae type b)	8, 12 and 16 weeks of age	
Pneumococcal (PCV)	Pneumococcal	8 weeks, 16 weeks and one year of age	
Rotavirus	Rotavirus infection	8 and 12 weeks of age	
Men B	Meningitis (caused by meningococcal type B bacteria)	8 weeks, 16 weeks and one year of age	
Hib/Men C	Haemophilus influenzae type b (Hib) and meningitis	One year of age	
MMR	Measles, mumps and rubella	One year and a second one at 13 months of age (in Southwark)	
Children's flu	Influenza	Annually as a nasal spray in Sept/Oct for ages two, three and four	
4-in-1 pre-school	Diphtheria, tetanus, whooping cough and polio	Three years and four months of age	