# GMS 1 - Patient Registration for Beech Tree Surgery, Selby

**PLEASE COMPLETE THIS FORM IN FULL USING BLOCK CAPITALS**

**In order to register you we will need sight of two forms of ID showing proof of occupancy of the home address you detail below. Ideally one form of ID will be photographic.**

***Staff use only***

***Date Received ..... Type of ID seen ..... Emis Number .....***

Your Named GP at the Practice Will Be **Dr Gupta**

**ALL QUESTIONS MARKED WITH * ARE MANDATORY (if applicable)**

*Have you ever been registered at this practice before? Yes ☐ No ☐

*Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐

*Sex: Male ☐ Female ☐

*Surname: _____

*Forename(s): _____

*Previous surnames: _____

*Date of Birth: _____

NHS No: _____

*Town & country of birth: _____

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*Home address: _____

_____

_____

*Postcode: _____

*Telephone No: _____

Mobile No: _____

*If you are over 16 years of age this Number will be used to remind you of pre booked appointments, change/cancel appointments via our free text reminder service. If you do not wish to receive text messages do not enter your mobile number. It is your responsibility to inform us of any change in this mobile number.*

If you are living in a Care Home are you a: ☐ Nursing or ☐ Residential patient

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

*****Your previous address in the UK: _____

_____

_____

*****Postcode: _____

*****Name of your previous doctor: _____

*****Address of your previous doctor: _____

_____

*****Postcode: _____

**If you are from abroad**

*****Your first UK address where registered with a GP: _____

_____

*****Postcode: _____

*****If previously resident in UK date of leaving: _____

*****Date you first came to live in the UK: _____

**If you are returning from the armed forces**

*****Address before enlisting: _____

_____

_____

*****Postcode: _____

*****Service: Army ☐ Navy ☐ RAF ☐

*****Service or Personnel No: _____

*****Enlistment date: _____ *****Date of leaving: _____

**If you are registering a child under 5**

I wish the child above to be registered with the practice for Child Health Surveillance ☐

**If you need your doctor to dispense medicines and appliances**

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 ☐

| **General Information** | |
|---|---|
| My height: _____ | My weight: _____ |

| **Do you suffer from one or more of the chronic diseases below?** Please tick ANY box that applies to you *** MANDATORY** | | | | | |
|---|---|---|---|---|---|
| Diabetes | ☐ | What type? _____ | | | |
| Heart Problem | ☐ | COPD | ☐ | Asthma | ☐ |
| Hypertension | ☐ | Chronic Kidney Disease | ☐ | | |

| **Employment status (over 16's only) -** Please tick the box that applies to you | | | | | |
|---|---|---|---|---|---|
| I am employed full time | ☐ | I am unemployed | ☐ | I am employed part time | ☐ |
| I am self | ☐ | I am a student | ☐ | | |
| I am retired | ☐ | I am medically retired | ☐ | | |

| **Assistance -** Please tick the box if it applies to you | | | |
|---|---|---|---|
| I have a Carer | ☐ | Carers Name: _____ | Carers Tel No.: _____ |

| **First language -** Please tick only 1 box | | | | | |
|---|---|---|---|---|---|
| English | ☐ | Portuguese | ☐ | Polish | ☐ |
| Kurdish | ☐ | Thai | ☐ | Cantonese | ☐ |
| Lithuanian | ☐ | Other (please specify) | ☐ | _____ | |

| **Ethnicity** – Please tick only 1 box | |
|---|---|
| **White** | |
| British (*9i0)* | ☐ |
| Irish (*9i1)* | ☐ |
| Any other white background (*9i2)* | ☐ |
| **Mixed** | |
| White & Black Caribbean (9i3) | ☐ |
| White & Black African (9i4) | ☐ |
| White & Asian (9i5) | ☐ |
| Any other mixed background (9i6) | ☐ |
| **Asian or British Asian** | |
| Indian (9I7) | ☐ |
| Pakistani (*9i8)* | ☐ |
| Bangladeshi (*9i9)* | ☐ |
| Any other Asian background (*9iA)* | ☐ |
| **Black or Black British** | |
| Caribbean (*9iB)* | ☐ |
| African (*9iC)* | ☐ |
| Any other background (*9iD)* | ☐ |
| **Any Other Ethnic Background** | |
| Chinese (*9iE)* | ☐ |
| Any other (please describe) (*9iF)* | ☐ _____ |
| **Do not wish to state ethnicity** | ☐ |

***Summary Care Record**

You have the 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. Your options are outlined below; please indicate your choice below:

1. ☐ **Express consent for medication, allergies and adverse reactions only.**
   You wish to share information about medication, allergies for adverse reactions only.

2. ☐ **Express consent for medication, allergies, adverse reactions and additional information.**
   You wish to share information about medication, allergies for adverse reactions and further medical information that includes: your illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

3. ☐ **Express dissent for Summary Care Record (opt out).**
   Select this option, if you DO NOT want any information shared with other healthcare professionals involved in your care.

If you chose not to complete this consent form, a core Summary Care Record (SCR) will be created for you, which will contain only medications, allergies and adverse reactions.

| **Family History -** Please tick ANY box that applies to you | | *** MANDATORY** |
|---|---|---|
| A member of my family suffers from **Diabetes**.<br>Q. Which family member? e.g. Mother, Father, Sister | | ☐ |
| A member of my family suffers from **Hypertension**.<br>Q. Which family member? e.g. Mother, Father, Sister | | ☐ |
| A member of my family suffers from **Heart Disease** and this started BEFORE they were 60 years of age.<br>Q. Which family member? e.g. Mother, Father, Sister | | ☐ |
| A member of my family suffers from **Asthma**<br>Q. Which family member? e.g. Mother, Father, Sister | | ☐ |

| **Smoking status** – Please tick only 1 box | *** MANDATORY** |
|---|---|
| I am a Smoker ☐ How many per day? _____<br>Cigarettes ☐ E-Cigarettes ☐<br>I am an Ex-smoker ☐<br>I have never smoked ☐<br>I am not willing to disclose ☐ | If you are a smoker and would like help in trying to stop please contact Living Well Smoke Free on 01609 797272<br>***Admin – please code 8Cal if smoker*** |

| **FAST Alcohol screening test (over 16's only)**<br>**1 drink= ½ pint of beer or 1 glass wine or 1 single spirits**<br>**Please tick only 1 box for each of the 4 questions below (388u)** | | | | | |
|---|---|---|---|---|---|
| **No of drinks per week you have?** | _____ | | | | |
| | 0 | 1 | 2 | 3 | 4 |
| **MEN**: How often do you have 8 or more drinks on one occasion? | ☐ Never | ☐ Less than monthly | ☐ Monthly | ☐ Weekly | ☐ Daily or almost daily |
| **WOMEN**: How often do you have 6 or more drinks on one occasion? | ☐ 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 |
| How often during the last year have you failed to do what was normally expected of you because of drinking? | ☐ Never | ☐ Less than monthly | ☐ Monthly | ☐ Weekly | ☐ Daily or almost daily |
| In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down? | ☐ No | | ☐ Yes, on once occasion | | ☐ Yes, on more than one occasion |

As you have applied to join our practice we would like to inform you of our practice policies.

**Repeat Prescriptions**

With a few exceptions we prescribe a 28 day supply of medication & to avoid repeat prescribing errors we do not accept requests for repeat prescriptions over the telephone. Requests for repeat prescriptions can be done in any of the following ways

- In person at the surgery, preferably with your counterfoil ticked appropriately, when closed we have a secure post box on the gate
- By post
- 'On line' via the NHS or Patient Access app (contact reception for log on details)

The prescription will be ready for collection/transmitted electronically to a pharmacy 2 working days after you have ordered.

If you use our main site in Selby please indicate below the name of the pharmacy you wish to use, your prescription will then be sent electronically direct to this pharmacy

I wish to use _____ pharmacy

**Confidentiality**
We are bound by strict criteria regarding disclosing your information to a third party, in general

- We will not disclose information to a third party without your written consent
- We will not disclose information to a parent/carer if the child is 16 years of age or older

If you are happy for us to disclose information to a third party we will need this in writing from yourself detailing the name of the person we can disclose information to. An alert will then be added to your record to this effect.

**Appointments**
Appointments can be booked by telephone, in person at the front desk in the surgery or via booking 'on line'. As we are a very busy surgery it is not always possible to offer routine appointments at short notice. However if you have a genuine medical emergency you will be offered a call back from the duty doctor who will assess your condition and respond accordingly. **Please note this service is for medical emergencies requiring urgent medical attention and not for reasons of convenience, i.e. sick notes, repeat medications, medical reports.**

**Home Visits**
Home visits take a long time and a doctor can see up to six patients in the surgery in the time it takes for just one home visit. We are only able to visit patients at home when there is a medical problem that makes it impossible for a patient to be brought to the surgery by car or taxi. The provision of transport is the patient's responsibility.

**Fail to attend**
Should you fail to attend for an appointment you may receive a letter, and after two failed to attend appointments we will write to you informing you that should this happen again you may be removed from the practice list.

**Violence and Aggression**
We operate a zero tolerance policy towards violence and aggression. Any patient who behaves in a violent or aggressive manner towards a member of staff or who is verbally abusive and uses foul language will be removed from our practice list and may be reported to the police.

I confirm that all details on this form are accurate and have read & agree to comply with the practice policies detailed.

*Signature of Patient _____ *Date _____

Or

*Signature on behalf of Patient: _____ *Date _____