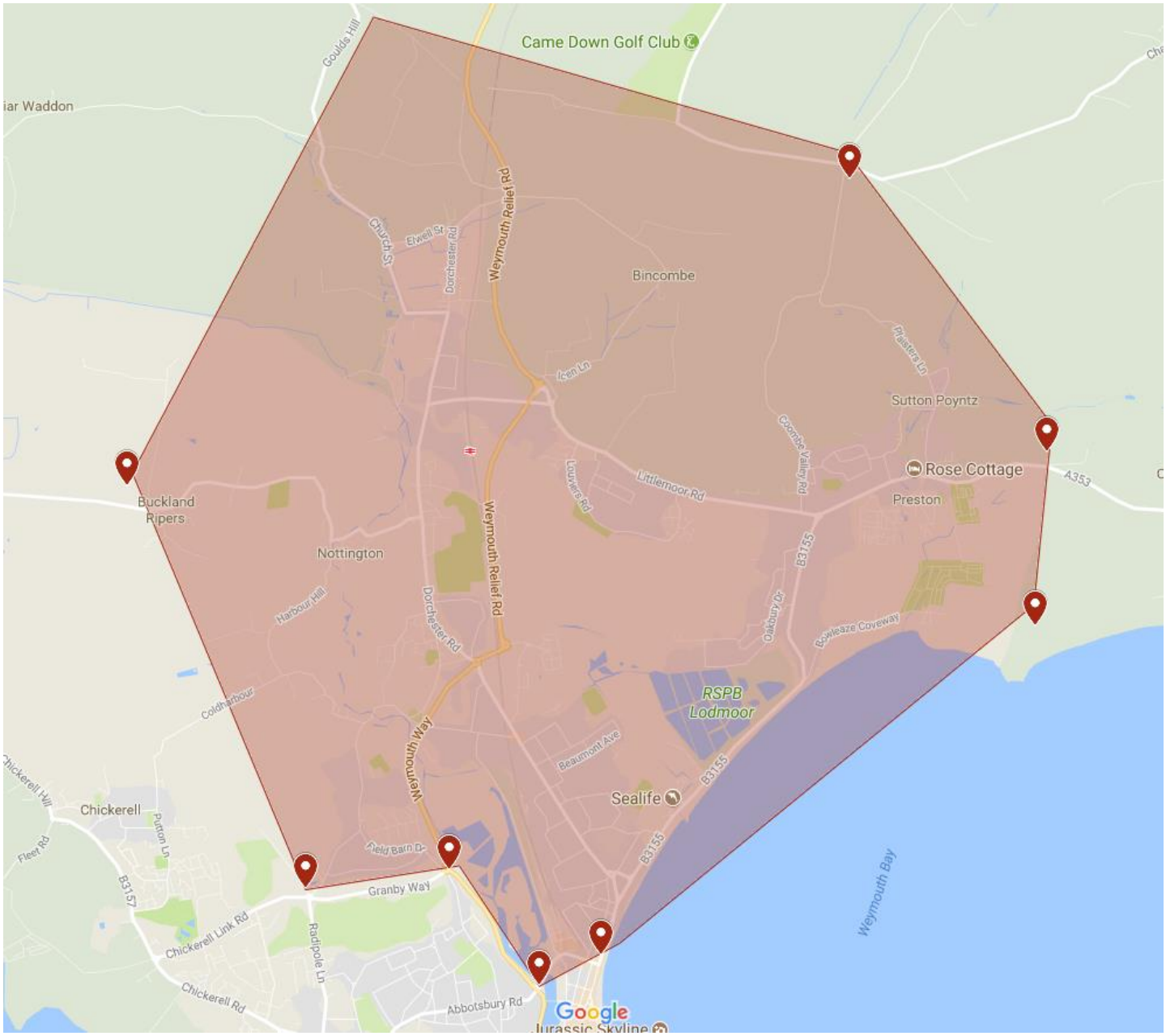
THE DORCHESTER ROAD SURGERY

NEW REGISTRATION PACK

In order to register at the Dorchester Road Surgery you will need to be living within our geographical area as shown on the boundary map below.



Please complete the following this registration pack in order to register at The Dorchester Road Surgery. Please note each patient will need to bring the completed forms along to the surgery personally with TWO forms of identification, one being a photographic identification and the other with details of your home address in the form of either of the following:

- Passport
- Driving Licence
- Birth Certificate
- Utility Bill

We are open every week day from 8.15 am – 6.00 pm.
Please note it can take up to 3-4 days for you to be added to our Practice register.
You do not need to contact your current surgery to register at The Dorchester Road Surgery.

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*

**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 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:

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

042017_003 Product Code: GMS1

NHS Family doctor services registration

GMS1

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

SUPPLEMENTARY QUESTIONS

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 another EEA 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		
	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

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.

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 The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

THE DORCHESTER ROAD SURGERY

UNDER 5s – New Patient Registration Questionnaire

Please complete this form and hand it back to Reception together with the purple GMS1 registration form if you are registering a child under the age of 5 at The Dorchester Road Surgery.

The Department of Health requires surgeries to collect information relating to patients' language and ethnicity. This form will also be passed to the Health Visiting Service. Thank you for completing this form.

Please complete in **BLOCK CAPITALS AND WRITE CLEARLY**

Personal Details:

Your CHILDS's **Forname(s):**	Your CHILD's **Surname**:
Your CHILD's **Date of Birth**:	Your CHILD's **NHS No**:

Your CHILD's Full Address:

Postcode:

Language and Ethnicity:

Language -

What is your child's first spoken language: ☐ English **or** ☐ Other (Please state which language): ……..

Ethnicity

To which ethnic group does your child belong?

- ☐ British or Mixed British
- ☐ White and Black Caribbean
- ☐ Other Ashian background
- ☐ African
- ☐ Chinese
- ☐ Other Ethnic group: please state: ……..
- ☐ Ethnic group not given (prefer not to say)

Parent's / Sibling Details:

Mother's Forename:	Mother's Surname:	Date of Birth:
Mother's Mobile tel no:	Mother's Landline tel no:	Work tel no:
Is this the mother registered at The Dorchester Road Surgery? YES / NO		
Father's Forename:	Father's Surname:	Date of Birth:
Father's Mobile tel no:	Father's Landline tel no:	Work tel no:
Is this the father registered at The Dorchester Road Surgery? YES / NO		

Are both parents living at the same address as the child: Yes ☐ No ☐

If not, please give another address and state which parent lives elsewhere:

Any other information:

Names of any siblings under 5 (continue overleaf if necessary)

…….. Date of Birth: …….

…….. Date of Birth: …….

Next of Kin Details:

Your CHILD's NEXT OF KIN details (Give Full Name and Title): DOB:

Relationship to CHILD (ie mother / father):

Is the Next of Kin at the same address as the Child? Yes ☐ No ☐

If not, please give address:

Is your next of kin registered at this practice:

☐ Yes ☐ No

Nominated Pharmacy:

Please state your child's nominated pharmacy (**this is required for ALL patients**):

Record Sharing:

Do you give consent for your GP Practice to share information with other people involved with your child's health care, eg Minor Injuries Unit, A&E, Ambulance Service. This is to improve communication to provide the best health care for your child. Please be reassured these agencies will still have to ask your permission each time they see your child.

Yes ☐ No ☐

Signed…… (Name in Full): ……Date: .....

(Parent/Guardian)

Date you are completing this form: ……

For surgery recoding use only:	☐ Patient Informed of named accountable GP (Xab9D) ☐ Patient allocated named accountable GP (XacWQ) ☐ Task sent to Health Visitor Team