Fremington Medical Centre

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New Patient Registration Pack
(Under 16 Years)

In this pack you will find the following:

- GMS1 Registration Form
- New Patient Questionnaire
- Data Sharing Preference Form
- Pharmacy Nomination & Repeat Prescriptions Form

To register, please can the parent/guardian or child (if over 13 years old) complete all the necessary forms in **BLOCK CAPITALS** and read through all the information contained within this pack carefully and retain for your records.

Once completed, please return all the application forms to reception along with some ID (preferably a copy of the child's original birth certificate), where a receptionist will then photocopy this and give it back to you. Please note that we will not be able to process the registration for you on the spot and it will take a few days for it to be finalised. If an urgent appointment is required with a clinician, please let the receptionist know and we will do our best to get you registered as soon as possible.

Note: If you would like to be recorded on our system as gender neutral, please select the "Mx" tick box in the title section on the GMS1 registration form.

**** It is a requirement that a handwritten signature is provided for registration ****

If as a parent/guardian, you would like online access to your child's medical record, please fill out a proxy online services application form, which are available from reception upon request.

Fremington Medical Centre
Registration Form

GMS1

PART 1

Title:	☐ Master ☐ Miss ☐ Mx	**First Name(s):**	
Date of Birth:		**Surname:**	
NHS Number:		**Previous Surname(s):**	
Gender:	☐ Male ☐ Female	**Town & Country of Birth:**	
Home Address: (Including Post Code)			

Home Telephone:		☐	Please tick **one** box to indicate your preferred contact number
Mobile Telephone:		☐	
Email Address:			

PART 2

Parent/Guardian's Details:			
Full Name:			Please tick **one** box to indicate your preferred contact number
Home Telephone:		☐	
Mobile Telephone:		☐	
Email Address:			

PART 3

Please help us trace your previous medical records by providing the following information:			
Previous Address in UK: (Including Post Code)			
Name of Previous Surgery:		**Name of Previous GP:**	

PART 4

Are you a previous UK resident returning from living abroad or have you just moved to the UK for the first time? *If yes, please enter your previous UK address in **PART 3***	**Date you left the UK:**	**Date you entered the UK:**
☐ Yes ☐ No		

PART 5

☐ **Signature of patient:**		**Date:**	
☐ **Signature on behalf of patient:**			

FOR PRACTICE USE ONLY	
Doctor's Name / Pooled List	**HA Code**

Verified By (Initials): _____ **Date:** _____ / _____ / _____	**Practice Stamp:**

Fremington Medical Centre
Registration Form

GMS1

PART 6

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:**	
Print Name:		**Relationship to patient:**	
On Behalf Of:			

PART 7

Complete this section if you live in another EEA country, 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:**
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.	**Country Code:**	
	3: Name:	
	4: Given Names:	
	5: Date of Birth:	
	6: Personal Identification Number:	
	7: Identification number of the institution:	
	8: Identification number of the card:	
	9: Expiry Date:	

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

Fremington Medical Centre
New Patient Questionnaire

Full Name:		Date of Birth:	

Who has parental responsibility? (Please tick **one** of the following)	☐ Joint (Mother & Father) ☐ Mother ☐ Father ☐ Guardian

Next of Kin:			
Full Name:			
Address:		**Relationship:**	
		Contact Number(s):	

Do you have a social worker or have had support from a social worker in the last 12 months?	☐ Yes ☐ No	**If yes, please state their name and contact details:**
Are you a young carer?	☐ Yes ☐ No	
Do you receive additional support from any other professional agency e.g. Speech and Language or CAMHS?	☐ Yes ☐ No	**If yes, please provide details:**
Do you require support to access the service specified above following a relocation?	☐ Yes ☐ No	

Have you had any of the following immunisations?	
8 Weeks Old: • Diphtheria, Tetanus, Pertussis (Whooping Cough), Polio & Haemophilus Influenza Type B (HIB) • Pneumococcal Disease • Rotavirus • Meningococcal Group B Disease (MenB)	☐ Yes ☐ No
12 Weeks Old: • Diphtheria, Tetanus, Pertussis (Whooping Cough), Polio & Haemophilus Influenza Type B (HIB) • Meningococcal Group C (MenC) • Rotavirus	☐ Yes ☐ No
16 Weeks Old: • Diphtheria, Tetanus, Pertussis (Whooping Cough) & Polio • Pneumococcal Disease • Meningococcal Group B Disease (MenB)	☐ Yes ☐ No
52 to 59 Weeks Old: • Haemophilus Influenza Type B (HIB) • Meningococcal Group C (MenC) • Pneumococcal Disease • Measles, Mumps & Rubella (German Measles) • Meningococcal Group B Disease (MenB)	☐ Yes ☐ No
2, 3 & 4 Years Old and Children in School Years 1 & 2: • Influenza	☐ Yes ☐ No
2 Years & 4 Months Old or Soon After: • Diphtheria, Tetanus, Pertussis (whooping cough) & Polio • Measles, Mumps & Rubella (German Measles)	☐ Yes ☐ No

Fremington Medical Centre
New Patient Questionnaire

We are now required to collect ethnicity and first language information from all our patients when registering with the practice. Please indicate your ethnicity group and first language by ticking one option from each of the tables below.

ETHNICITY	
☐ White British	☐ Other Asian Ethnic Group
☐ White Irish	☐ Black African
☐ Other White Ethnic Group	☐ Black Caribbean
☐ Indian	☐ Other Black Ethnic Group
☐ Pakistani	☐ Mixed Origin
☐ Bangladeshi	☐ Other Ethnic Group
☐ Chinese	☐ Ethnic Group Not Stated

FIRST LANGUAGE	
☐ English	☐ Polish
☐ British Sign Language	☐ Cantonese
☐ French	☐ Mandarin
☐ German	☐ Ukrainian
☐ Spanish	☐ Russian
☐ Italian	☐ Other (please specify):

Will you need any help from an interpreter or translator during contact with us?	☐ Yes ☐ No

Please detail below if any of the following apply to you:		
Sensory impairment?	☐ Yes ☐ No	**If yes, please specify:**
Assistance dog user?	☐ Yes ☐ No	
Physical disability?	☐ Yes ☐ No	**If yes, please specify:**
Special requirements to access the practice premises?	☐ Yes ☐ No	**If yes, please specify:**
Mental and/or hidden disability?	☐ Yes ☐ No	**If yes, please specify:**
Allergies or sensitivities?		
Religious or cultural needs?		

ACCESSIBLE INFORMATION STANDARD
If you require communication support such as by email or large format letters due to a disability, impairment or sensory loss, please specify below:

YOUR MEDICAL HISTORY
If you have any serious illnesses or chronic conditions, please specify below:

Fremington Medical Centre
Data Sharing Form

Please complete the form below to indicate your personal decisions regarding the aspects of patient data sharing for health care purposes. It is very important that you sign this form to say you understand and accept the risks to your personal health care if you do decide to opt out of SCR or EDSM.

Full Name:	
Date of Birth:	

SCR - NHS Summary Care Record

Please tick only one box:

- ☐ Express consent for medication, allergies and adverse reactions only
- ☐ Express consent for medication, allergies, adverse reactions & additional info **(recommended)**
- ☐ Express dissent for patients who do not want a summary care record and fully understand the risks involved with this decision

EDSM - Enhanced Data Sharing Model (SystmOne)

Sharing Out - Do you consent to the sharing of data recorded by your GP practice with other organisations and care services that may care for you?

Please tick only one box:

- ☐ Consent Given **(recommended)**
- ☐ Consent Refused; I fully accept the risks associated with this decision

Sharing In - Do you consent to your GP practice viewing data that is recorded with other organisations and care services that may care for you?

Please tick only one box:

- ☐ Consent Given **(recommended)**
- ☐ Consent Refused; I fully accept the risks associated with this decision

Signature:	
Date:	

Fremington Medical Centre
Pharmacy Nomination & Repeat Prescriptions Form

Full Name:	

Date of Birth:	

You must nominate <u>one</u> of the pharmacies below to receive your prescriptions electronically:	
Boots Fremington	☐
Boots Roundswell	☐
Boots High Street Barnstaple	☐
Tesco Severn Brethren	☐
Arnolds Westward Ho!	☐
Lloyds Direct	☐
Pharmacy2u	☐
Other (Please specify):	☐

Please tick **Yes** or **No** if you regularly receive medication by repeat prescription:
☐ Yes ☐ No
The practice will need to add any regular medications onto a repeat prescriptions list. This allows for easy re-ordering each time your medication is ordered. **If you ticked YES and take regular medication, please supply when registering any repeat prescription slips, listing your medication for the Pharmacy Team to review and add to your repeat medication list. It may be appropriate for the clinicians to review your medication with you, in which case one of the Reception Team will contact you to arrange this.** **** Please ensure you have at least 2-4 weeks' worth of medication before registering with us ****