Riverside Medical Practice

Ferry Road, Halling, Rochester, Kent, ME2 1NP (01634 240238)
19A Wood St. Cuxton, Rochester, Kent, ME2 1LT (01634 714317)
riversidemedicalpractice.com

New Patient Registration Pack

Welcome to Riverside Medical Practice. Please complete your registration pack and return to reception in person. If you would like to use online services, such as the NHS App to access your medical records or to order your repeat medication we will request to see you with a form of photo ID when you hand in your registration form, so that we can set this up for you.

If you do have any repeat medications, please ensure you have a 4 week supply from your previous GP before handing in your registration form. It can take a time for your records to come over to us, however if you can supply us with a list of your repeat medications from your previous GP we can add this to our records to endeavour to ensure that your medications are not disrupted in your transfer to our practice.

Registration Part 1 – About You

Please complete your details below:

Forename: _____ Surname: _____

Date of Birth: _____/_____/_____

Address: _____

_____

Postcode: _____

Contact Numbers: Mobile: _____ Landline: _____

Email Address: _____

Do you have a preferred method of contact for us to use? _____

Do you have any communication difficulties that we need to be made aware of? (For example do you have difficulty hearing or require an interpreter?)

Please tick your ethnic group below:

☐ **White** English, Welsh, Scottish, Northern Irish or British / Irish / Gypsy or Irish Traveller / Any other White Background.	☐ **Mixed or Multiple ethnic groups** White and Black Caribbean / White and Black African / White and Asian / Any other Mixed or Multiple ethnic background	☐ **Asian or Asian British** Indian / Pakistani / Bangladeshi / Chinese / Any other Asian background	☐ **Black, African, Caribbean or Black British** African / Caribbean / Any other Black, African or Caribbean background	☐ **Other Ethnic Group** Arab / Any other ethnic group

Please sign to confirm that you have received and understood the Privacy Notice (enclosed in the practice leaflet).			
Signature		**Date**	

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 GP practice while at that address

Address of previous GP practice

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

Were you ever registered with an Armed Forces GP

Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas: ☐ Regular ☐ Reservist ☐ Veteran ☐ Family Member (Spouse, Civil Partner, Service Child)

Address before enlisting:

Postcode

Service or Personnel number: Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable)

Footnote: These questions are optional and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services.

If you need your doctor to dispense medicines and appliances*

☐ I live more than 1.6km in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

**Not all doctors are authorised to dispense medicines*

☐ **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

Signature confirming my consent to join the NHS Organ Donor Register **Date** _____/_____/_____

Please tell your family you want to be an organ donor. If you do not want to be an organ donor, please visit www.organdonation.nhs.uk or call 0300 123 23 23 to register your decision.

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 my consent to join the NHS Blood Donor Register **Date** _____/_____/_____

My preferred address for donation is: (only if different from above, e.g. your place of work) Postcode:

All blood types are needed, especially O negative and B negative. Visit www.blood.co.uk or call 0300 123 23 23.

NHS England use only Patient registered for ☐ GMS ☐ Dispensing

Family doctor services registration

GMS1

To be completed by the GP Practice

Practice Name | Practice Code

☐ I have accepted this patient for general medical services on behalf of the practice

☐ I will dispense medicines/appliances to this patient subject to NHS England approval.

I declare to the best of my belief this information is correct

Practice Stamp

Authorised Signature

Name | Date / /

SUPPLEMENTARY QUESTIONS QUESTIONS - These questions and the patient declaration are optional and your answers will not affect your entitlement to register or receive services from your GP.

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
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.		
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 costs from your home country

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Registration Part 2 – Your Health

Please answer the questions below about yourself:

The information that you provide us with will help the doctor to make an initial assessment about your health which will help in your future treatment. Patients are able to attend the practice for an initial consultation for some basic checks with the nurse. Please speak to a receptionist if this is something you are interested in.

About You:

Forename: _____ Surname: _____
Date of Birth: _____/_____/_____
Height: _____
Weight: _____
Occupation: _____

Exercise

Do you take regular exercise? **YES / NO**
If yes, what sort of exercise? **VERY ACTIVE / MILDLY ACTIVE / GENTLE EXERCISE**
How many times per week? _____

Smoking Status

Do you smoke? **YES / NO**
If Yes, how many per day? **Cigarettes** _____ **Cigars** _____ **Ounces of Tobacco** _____
If you are an Ex-Smoker, when did you give up? _____

Alcohol

For the following questions please circle the answer which best applies to you.
1 drink = 1/2 pint of beer or one glass of wine or 1 single spirits

Men: How often do you have EIGHT or more drinks on one occasion?
Women: How often do you have SIX 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 one occasion*** ***Yes on more than one occasion***

How many units of alcohol do you drink in 1 week? _____

Medication

Please supply us with details (name, dosage, form e.g. tablets, capsules, liquid) of any medication which you take (prescribed or otherwise). It is helpful if you can supply us with a copy of your repeat medication sheet from your previous GP.

_____
_____
_____
_____
_____

Allergies

Are you allergic to any substances or foods? **YES / NO**

If yes, please give details:

_____

Immunisations

Dates of Triple/Polio/HIB: _____

Dates of MMR: _____

Date of last Tetanus: _____

Female Patients

Date of most recent Cervical Smear Test: _____

Result: _____

Please give details of any complications in pregnancy: _____
_____
_____

Carers

Do you need or have anyone who looks after you and your daily needs as a Carer? **YES / NO**

If yes, would you like them to deal with your health affairs here? **YES / NO**

(If yes, the receptionist can help with these arrangements)

Do you care for anyone else? **YES / NO** *(If yes, you can ask the receptionist about carers support)*

General

Are there any issues which cause you concern or would you like advice on any other health problems? Please give details below.

_____
_____
_____
_____
_____

Thank you for completing this information. We appreciate the time you have spent doing this and will update your medical records accordingly.

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Registration Part 3 – Access to online GP Services (NHS APP)

Forename		Surname	
Date of Birth			
Address			
Postcode			
Email Address			

I wish to have access to the following online services (tick all that apply):

1. Booking appointments	☐
2. Requesting repeat prescriptions	☐
3. Accessing my medical record	☐

Application for online access to my medical record

I wish to access my medical record online and understand and agree with each statement below (please tick)

1. I have read and understood the information leaflet provided by the practice	☐
2. I will be responsible for the security of the information that I see or download	☐
3. If I choose to share my information with anyone else, this is at my own risk	☐
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement	☐
5. If I see information in my record that it not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible	☐

Messaging Facility:

I hereby give my consent to Riverside Medical Practice to send me text messages for appointment reminders and all other routine reviews *(please tick).*

Yes ☐ No ☐

I hereby give my consent to riverside Medical Practice to leave voicemail messages if I am unavailable on mobile messaging only.

Yes ☐ No ☐

Signature		**Date**	

For Practice Use Only:

Identity verified through (tick all that apply)	**Vouching ☐** **Vouching with information in record ☐** **Photo ID ☐** **Proof of residence ☐**	**Name of verifier**	**Date**
Name of person who authorised (if applicable)			**Date**
Date account created			
Date passphrase sent			

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Registration Part 4 – Your Summary Care Record

Dear patient.

If you are registered with a GP practice in England, you will already have a Summary Care Record (SCR), unless you have previously chosen not to have one. It will contain key information about the medicines you are taking, allergies you suffer from and any adverse reactions to medicines you have had in the past.

Information about your healthcare may not be routinely shared across different healthcare organisations and systems. You may need to be treated by health and care professionals who do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs.

Having a Summary Care Record can help by providing healthcare staff treating you with vital information from your health record. This will help the staff involved in your care make better and safer decisions about how best to treat you.

You have a choice

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 by ticking the correct box below.

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

Name _____

Date of Birth ____ / ____ / ____

Signature _____ Date _____

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.

You are free to change your decision at any time by informing your GP practice.

You can also download a form and find further information at the following website:
www.nhscarerecords.nhs.uk/options

Thank you.

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Registration Part 5 – Register your Type 1 Opt-Out Preference

The data held in your GP medical records is shared with other healthcare professionals for the purposes of your individual care. It is also shared with other organisations to support health and care planning and research.

If you do not want your personally identifiable patient data to be shared outside of your GP practice for purposes except your own care, you can register an opt-out with your GP practice. This is known as a Type 1 Opt-out.

Type 1 Opt-outs may be discontinued in the future. If this happens then they may be turned into a National Data Opt-out. Your GP practice will tell you if this is going to happen and if you need to do anything. More information about the National Data Opt-out is here: https://www.nhs.uk/your-nhs-data-matters/

You can use this form to:

- register a Type 1 Opt-out, for yourself or for a dependent (if you are the parent or legal guardian of the patient) (to **Opt-out**)
- withdraw an existing Type 1 Opt-out, for yourself or a dependent (if you are the parent or legal guardian of the patient) if you have changed your preference (**Opt-in**)

This decision will not affect individual care and you can change your choice at any time, using this form. This form, once completed, should be sent to your GP practice by email or post.

Details of the patient

Title										
Forename(s)										
Surname										
Address										
Phone number										
Date of birth										
NHS Number (if known)										

Details of parent or legal guardian

If you are filling in this form on behalf of a dependent e.g. a child, the GP practice will first check that you have the authority to do so. Please complete the details below:

Name	
Address	
Relationship to patient	

Your Decision

☐ **Opt-out**

I do not allow my identifiable patient data to be shared outside of the GP practice for purposes except my own care.

OR

I do not allow the patient above's identifiable patient data to be shared outside of the GP practice for purposes except their own care.

☐ **Withdraw Opt-out (Opt-in)**

I do allow my identifiable patient data to be shared outside of the GP practice for purposes beyond my own care.

OR

I do allow the patient above's identifiable patient data to be shared outside of the GP practice for purposes beyond their own care.

Your declaration

I confirm that:

- the information I have given in this form is correct
- I am the parent or legal guardian of the dependent person I am making a choice for set out above (if appliable)

Signature ☐

Date signed ☐

When complete, please return to your GP practice

For GP Practice Use Only

Date received		
Date applied		
Tick to select the codes applied	**Opt – Out - Dissent code:** 9Nu0 (827241000000103 |Dissent from secondary use of general practitioner patient identifiable data (finding)|)	
	Opt – In - Dissent withdrawal code: 9Nu1 (827261000000102 |Dissent withdrawn for secondary use of general practitioner patient identifiable data (finding)|)]	