

## Family doctor services registration GMS1

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	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 prev Your previous address in UK	ious medical records by providing the following information  Name of previous GP practice while at that address
	Address of previous GP practice
	· · ·
If for a short of	
If you are from abroad Your first UK address where registered	with a GP
If previously resident in UK,	Date you first came
date of leaving  Were you ever registered with	to live in UK
	e UK Armed Forces and/or been registered with a Ministry of Defence GP in the rvist   Veteran   Family Member (Spouse, Civil Partner, Service Child)
	Postcode
Service or Personnel number:	1 osteode
Footnote: These questions are optional	Enlistment date: DD MM YY Discharge date: DD MM YY (if applicable) and your answers will not affect your entitlement to register or receive services to some NHS priority and service charities services.
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Footnote: These questions are optional from the NHS but may improve access a lif you need your doctor to dis  I live more than 1.6km in a strain I would have serious difficulty  Signature of Patient  NHS Organ Donor registration I want to register my details on the NHS after my death. Please tick the boxes that Any of my organs and tissue or	and your answers will not affect your entitlement to register or receive services to some NHS priority and service charities services.  pense medicines and appliances*  inight line from the nearest chemist  Signature on behalf of patient  Date  Date  The law recently changed and now everyone is signed up automatically unless you err Corneas Lungs  Corneas Lungs  And affect your entitlement to register or receive services are authorised to dispense medicines  *Not all doctors are authorised to dispense medicines  The law recently changed and now everyone is signed up automatically unless you Pancreaopt-out.)
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If you need your doctor to dis  I live more than 1.6km in a stra  I would have serious difficulty  Signature of Patient  NHS Organ Donor registration I want to register my details on the NHS after my death. Please tick the boxes that Any of my organs and tissue or Kidneys Heart Live Signature confirming my consent to je  Please tell your family you want to be ar www.organdonation.nhs.uk or call 03000  NHS Blood Donor registration	and your answers will not affect your entitlement to register or receive services to some NHS priority and service charities services.  pense medicines and appliances*  inght line from the nearest chemist  in getting them from a chemist    Signature on behalf of patient   Date
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## To be completed by the GP Practice

Practice Name  Willow Tree F		Practice Code <b>E84015</b>			
☐ I have accepted this patie	ent for general medical services on b	ehalf of th	e practice		
I will dispense medicines/a	ppliances to this patient subject to	NHS Englan	d approval.		
I declare to the best of my belief	this information is correct		Dragtica Staron		
				Practice Stamp	
			VVIII	low Tree Family Doctors	
Authorised Signature				13b Stag Lane	
Name	Date/	_/		ndon NW9 9AD 0208 204 6464	
	<u>S QUESTIONS</u> - These questions and entitlement to register or receive ser			re optional and your	
PATIENT DEC	LARATION for all patients who a	re not ordi	narily residen	t in the UK	
Anybody in England can register	with a GP practice and receive free me	edical care fr	om that practice	÷.	
	ily resident' in the UK you may have to				
, ,	ns living lawfully in the UK on a properl an Economic Area must also have the st	,		,	
	tests of suspected infectious diseases a				
1	ho are not ordinarily resident here are	-			
	esidence, exemptions and paying for NI	HS services ca	n be found in t	he Visitor and Migrant	
Patient leaflet, available from yo	our GP practice. oof of entitlement in order to receive f	roo NHS tros	tment outside o	of the GP practice otherwise	
	eatment. Even if you have to pay for a				
	t treatment, regardless of advance pay		,,		
	s form will be used to assist in identify		-		
-	sations (e.g. hospitals) and NHS Digital I on behalf of the NHS to confirm any o	-		ion, invoicing and cost	
Please tick one of the following	•	actuiis you ii	ave provided.		
a) I understand that I may i	need to pay for NHS treatment outside	of the GP n	ractice		
	lid exemption from paying for NHS tr			vractice. This includes for	
	of the Immigration Health Charge ("th				
provide documents to support t	his when requested				
c) I do not know my charge	able status				
I declare that the information I	give on this form is correct and comple	ete. I unders	tand that if it is	not correct, appropriate	
action may be taken against me					
A parent/guardian should comp	plete the form on behalf of a child und	ler 16.		Γ	
Signed:		Date:		DD MM YY	
Print name:		Relation	nship to		
On behalf of:		patient	-		
	ive in another EEA country, or have				
	EEA member state. Do not complete INSURANCE CARD (EHIC), PROVISIO				
DETAILS and S1 FORMS	INSONAIVEE CARD (EITIC), I ROVISIO	MAE ILEI EA	CLIVILITY CLIVI	incare (inc)	
Do you have a <u>non-UK</u> EHIC o	r PRC? YES: NO:		s, please enter below:	details from your EHIC or	
EUROPEAN HEALTH INSURANCE CAND	Country Code:				
	3: Name				
	4: Given Names				
Commission of the control of the con	5: Date of Birth	DD MM YYYY			
If you are visiting from another I	6: Personal Identification Number				
If you are visiting from another E country and do not hold a curre EHIC (or Provisional Replacemen	7: Identification number of the institution				
Certificate (PRC))/S1, you may be for the cost of any treatment rec	seived 8: Identification number				
outside of the GP practice, include at a hospital.	9: Expiry Date	DD MM Y	YYY		
·	From: DD MM YYYY	DD IVIIVI I	(b) To	: DD MM YYYY	
				_	
	1 (e.g. you are retiring to the UK or t work in another EEA member state				
and GP appointment data will	ata be used? By using your EHIC or P I be shared with NHS secondary care a will not be shared in the cost reco	(hospitals)	and NHS Digita		

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.

## CHIGWELL MEDICAL CENTRE 300 Fencepiece Road, London, IG6 2TA

## **New Patient Registration – Child/Young Person (0-18yrs)**

Date:			
Surname:	Forename:	Date of Birth:	Gender:
Current Address:			Post Code:
Previous Address:			Post Code:
NHS Number:	Place of Birth:	Telephone Nu	ımber:
Registered GP:	<del></del>		
Ethnic Origin:	(Please select from be	elow picking list)	
Black – other, non mi	xed origin / Black – other,	ckground / Black Caribbean / Black Afri , mixed / Indian / Pakistani / Bangladesh mixed origin / Vietnamese / Other Asian	ni / Chinese
Main language spoken:			
<b>Lifestyle Questionnaire</b> Weight: Height:			
Allergy to Drugs (Pleas state which	ch):		
Medical History Serious Illness:		Date	
			-
		Date	
		Date	-
Carer/Daytime Details Primary Carer:		Carer's Telephone:	
Relationship of Carer to child/you	ng person:		
Name of School:		School Telephone Number:	
Current Medications and Dose			
1	2	3	
4	5	6	
Family History Heart Disease Y/N		Immunizations: Diphtheria/Tetanus/Pertussis/F	Polio/Hib/Menigitis
Diabetes Y/N Strokes Y/N		1 <sup>st</sup> Dose (8 weeks)	
Asthma Y/N Cancer Y/N		2 <sup>nd</sup> Dose (12 weeks)	
		3rd Dose (16 Weeks)	
		MMR (12 months)	
Name of Person completing this form:		Diphtheria/Tetanus/Pertussis/F	Polio/MMR (4 ½ years) _
		Diphtheria/Tetanus//Polio Boo	oster (15 Years)
Signed:		Other: BCG Me	ningitis