Registration information for 0-16 yrs old

(CAPITAL LETTERS)

Child's Name: ______________________________

Mothers Name: ______________________________

Mothers Date of Birth: ______________________________

Mothers Email: ______________________________

Mothers tel.: ______________________________

Fathers Name: ______________________________

Fathers Date of Birth: ______________________________

Fathers Email: ______________________________

Fathers tel.: ______________________________

Next of Kin name: ______________________________

Relationship to child: ______________________________

Contact number: ______________________________

0-6 imms record is mandatory

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

The Fryent Way Surgery

Application for online access to my medical record

First name	Surname
Date of Birth	
Address	
Postcode	
Email address (CAPITAL LETTERS)	
Landline number	Mobile number

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

1. Booking appointment	☐
2. Requesting repeat prescriptions	☐
3. Access to my medical record	☐

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

1. I have read & understood the leaflet '*What you need to know about your online GP records*'	☐
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 is not about me or is inaccurate I will contact the practice as soon as possible	☐

Signature	Date

For staff use only

ID verified by (initials):	**Date:**	**Method**
		Vouching ☐ Vouching with information in record ☐ Photo ID ☐