

**New Patient Information Pack – Under 16’s**

**Welcome to King’s Medical Centre**

Please find the enclosed:

* GMS1 form
* New Patient Health Questionnaire

Please complete the GMS1 form completing all sections and make sure your NHS number is on the form; this is a ten digit number.

The new patient health questionnaire must be completed as fully as possible to enable us to process your registration quickly and efficiently.

If you receive regular medications from your previous GP, a repeat prescription reordering slip must be attached to this form.

Once you have completed all the forms please hand them in at the reception.

**If you would like this letter or information in an alternative format, for example large print or easy read, or if you need help with communicating with us, for example because you use British Sign Language, please let us know. You can call us on 01623 551015 / 559992.**

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| **Useful Information** |
| * Our address is King Street, Sutton-in-Ashfield, Notts, NG17 1AT * Our telephone lines are open from 8am until 6.30pm, Monday to Friday. Appointment lines are open from 8.30am. * Please ask at reception for a practice information booklet * If your surname begins with A to I, your named GP will be Dr Chilamkurthi * If your surname begins with J to R, your named GP will be Dr Chakraborty * If your surname begins with S to Z, your named GP will be Dr Yadlapalli |

**New Patient Questionnaire**

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| **Patient Details** | | | | | | | | | | |
| Title: |  | First Name(s) / Middle Name: | |  | | | | Surname: | |  |
| Date of Birth: | |  | | NHS no: |  | | | Sex: | |  |
| Home Address:  Postcode: | | | | | | | | | | |
| Marital Status: | | | | | | | | | | |
| Main spoken language: | | | | | | | | | | |
| Do you have any communication difficulties? Yes ☐ No ☐  If yes, please identify: | | | | | | | | | | |
| Telephone numbers:  Mob\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | Do you consent to text messaging service?  Yes ☐ No☐ | | | | |
| Preferred method of communication  Letter ☐ SMS☐ | | | | |
| **Ethnic Group** | | | | | | | | | | |
| White UK☐  White Irish ☐ | | | Black Caribbean ☐  Black African ☐  Black Other ☐ | | | | Bangladeshi ☐ Indian ☐ Pakistani ☐ | | Arabic ☐ Chinese ☐ Other ☐ Please specify | |

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| **Next of Kin** | | | |
| Full name: |  | Relationship to you: |  |
| Address: |  | Contact details: |  |

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| **Medical History** | | | |
| Do you suffer with any of the following? | | | |
| ☐Asthma  ☐COPD  ☐Epilepsy  ☐Depression | ☐Heart disease  ☐Heart failure  ☐High blood pressure  ☐Learning disabilities | ☐Diabetes ☐Kidney disease ☐Stroke ☐ Visually impaired | ☐Depression ☐Hypothyroidism ☐Hearing impaired ☐Cancer – type: |
| Any other conditions, operations or hospital admission details: | | | |

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| **Family History** | | |
| Have your parents, brothers or sisters have any of the following? | | |
| **Condition** | **Relationship** | **Age of Onset** |
| Diabetes |  |  |
| Heart Attack / Angina |  |  |
| Stroke |  |  |
| Bowel Cancer |  |  |
| Breast Cancer |  |  |
| Ovarian Cancer |  |  |
| Thrombosis |  |  |

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| **Allergies** |
| Please give details of any allergies you have: |

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| **Medication** |
| Do you have a repeat prescription from your previous GP surgery? Yes ☐ No ☐ |
| Would you like to sign up for electronic prescribing? Yes ☐ No ☐  If yes, which pharmacy would you like to be signed up with? |
| **Please note – For us to be able to process your current medication on to your records, we will need a copy of either your repeat slip or a copy of your labelled boxes.** |

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| **Your Summary Care Record (SCR)** |
| Do you consent to having an Enhanced Summary Care Record with Additional Information?  *A summary care record is an electronic record of your medical information including any medication history and allergies. It will allow healthcare staff to have quicker access to your record and they can provide you with safer care during an emergency. For more information, please speak to a receptionist.*  ☐ Yes *(recommended option)*  ☐ No |

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| **Signature** | |
| Signature  (signed on behalf) | ☐I confirm that the information I have provided is true to the best of my knowledge |
| Name |  |
| Date |  |

**For Practice Use Only**

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| Appointment details |  |
| Photo ID | ☐Passport☐Identity Card ☐Other:☐No – Reason: |
| ID | ☐Birth Certificate ☐Red Book ☐No – Reason: |
| NHS number | ☐Yes ☐No - Reason: |
| Previous GP | ☐Yes ☐No - Reason: |
| Previous address | ☐Yes ☐No - Reason: |
| Checked by:  Date: |  |