NHS Scotland logoAPPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE

**ALL FIELDS MARKED \* ARE MANDATORY AND MUST BE COMPLETED AS FULLY AS POSSIBLE**

# PERSONAL DETAILS

Is this your first registration with a

GP Practice in the UK?

Yes  No 

Will you be in the area for more than 3 months?

Yes No

Male \*

Female \*

*(If ‘No’, please complete a temporary resident form)*

Date of birth \* Address \*

Title \*

Surname \*

Forenames \*

Previous surname \* Postcode \*

Telephone #

Email address # Mobile #

*# the data supplied in these fields will not be input to, or updated in, the Community Health Index (CHI), but will be held on the GP Practice’s system.*

The following information can be found on your **current medical card**:

Community Health Index (CHI) number \* NHS number \*

The following information can be found on your **birth certificate**:

Town of birth \* Country of birth \*

Registered district of birth

*(Scotland only)*

Mother’s maiden name

# HELP US TO TRACE YOUR PREVIOUS GP HEALTH RECORDS BY PROVIDING THE FOLLOWING INFORMATION

Address in UK when you were last registered with a GP \*

Postcode \*

Name and address of previous GP Practice in UK \*

Postcode \*

## If you are from abroad:

Date you first came to live in the UK \* If previously resident in the UK, date of leaving \*

Your most recent country of residence

**If you have served in the British Armed Forces:** Service Number Enlistment date \*

Are you a Reservist? Leaving date \*

Yes No

If yes provide your address before enlisting \*

Postcode \*

Is this your first registration with a GP since leaving the armed forces? Yes No

# VOLUNTARY AUTHORISATION FOR ORGAN OR TISSUE DONATION

You have a choice about organ or tissue donation after your death. To find out more about why it is important that you take the time to make your donation decision and record it, go to [www.organdonationscotland.org](http://www.organdonationscotland.org/)

# HOW WE USE INFORMATION

The information you have provided will be used by NHS Scotland to carry out its various functions and services including scheduling appointments, ordering tests, hospital referrals and sending correspondence.

Your information, including your name, gender, date of birth and address, will be passed to NHS National Services Scotland where it will be held on the Community Health Index (CHI). This information is used to register you with the GP Practice, transfer your medical records between GP practices in the UK, make payments to GP Practices for medical services provided, and to process and issue medical exemption certificates and entitlement cards.

NHS National Services Scotland shares information about you within NHSScotland to assist in the provision and improvement of NHS services and the health of the public. When we do this, we do it as described by NHS Scotland in the NHS Inform website under the “How the NHS handles your personal health information” section.

NHS Scotland is made up of various organisations such as NHS Health Boards, GP practices, the Scottish [Ambulance Service or NHS National](https://www.nhsinform.scot/care-support-and-rights/health-rights/confidentiality-and-data-protection/how-the-nhs-handles-your-personal-health-information) [Services Scotland (the](https://www.nhsinform.scot/care-support-and-rights/health-rights/confidentiality-and-data-protection/how-the-nhs-handles-your-personal-health-information) common name of the Common Services Agency for the Scottish Health Service). These organisations are individually responsible for your personal health information. In terms of data protection and privacy laws, they are known as ‘data controllers’.

Find out more about NHS Scotland in the link provided above.

# PATIENT DECLARATION

I declare that the information I have given on this form is correct and complete. I understand that, if it is not, appropriate action may be taken. To enable NHS National Services Scotland to confirm my eligibility to lawfully register with a GP and for the purposes of prevention, detection, and investigation of crime, the minimum necessary information from this form could be disclosed to relevant authorities.

I understand that more comprehensive information about how NHS Scotland handles my data is available from NHS Inform.

This information can be provided in other languages and formats on request. The NHS Inform helpline provides an interpreting service.

Patient / Patient’s representative signature Representative’s name (if applicable) Relationship to patient (if applicable)

Date \*

# FOR PRACTICE USE

GP reference number GP name

Practice code

## Identification seen – do not take or retain photocopies

Please initial each relevant box (it is recommended that at least one form of the identification is seen to positively identify the applicant although it is not mandatory to provide identification to register)

Birth cert

Student ID card

Driving licence

Passport or HC2 cert

Home Office

app reg card

Other / None

I accept this patient onto the practice list and declare that, to the best of my knowledge, this information is correct. I acknowledge that the details may be

authenticated from appropriate records, and that payments generated from this patient registration will be subject to Payment Verification.

Authorised Practice signature Date \*

# FOR OFFICIAL USE ONLY

Input by Checked by Date

Practice stamp

2 GMSGPR001 V27 1 2021

**New Patient Questionnaire**

Surname \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Forename/s \_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Maiden Name \_\_\_\_\_\_\_\_\_\_\_\_

Work Tel No ­­­­\_\_\_\_\_\_\_\_\_ Mobile \_\_\_\_\_\_\_\_\_ Home Tel No \_\_\_\_\_\_\_\_\_\_\_\_

Marital status ­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Emergency Contact \_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Their Daytime Tel No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Evening/Mobile No \_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER PEOPLE WHO LIVE AT THE SAME ADDRESS**

|  |  |  |
| --- | --- | --- |
| **Name** | **Date of Birth** | **Relationship to you** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**ETHNIC ORIGIN**

Please tick the appropriate box – or the last box if you do not wish to give this information

|  |  |  |  |
| --- | --- | --- | --- |
| 9S13 White Scottish |  | 9S6 Indian |  |
| 9S14 Other White British |  | 9S7 Pakistani |  |
| 9S11 White Irish |  | 9S8 Bangladeshi |  |
| 9S12 Other White Ethnic |  | 9S9 Chinese |  |
| 9SB Other Ethnic Mixed Origin |  | 9SH Other Asian Ethnic Group |  |
| 9S2 Black Caribbean |  | 9SJ Other Ethnic Group |  |
| 9S3 Black African |  |  |  |
| 9SG Other Black Ethnic Group |  | 9SD Ethnic Group - refused |  |

**Please tell us about serious illnesses in your family especially heart disease, strokes, cancer, asthma, diabetes and glaucoma**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Age** | **Illness** | **Age of onset** | **Age of death** | **Cause of death** |
| **Father** |  |  |  |  |  |
| **Mother** |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

If you need to see a GP or nurse please bring any medication you are taking to your first appointment.

Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Usual type of alcohol taken is \_\_\_\_\_\_\_\_\_\_\_ Alcohol: \_\_\_\_\_\_ units per day

(One unit is about ½ pint of beer, one pub measure spirits or one glass of wine)

**SMOKING STATUS – ARE YOU? – PLEASE CIRCLE ONE**

A smoker Yes/No How Many Per Day? \_\_\_\_\_\_\_\_\_

An Ex-smoker Yes/No If so when did you stop? \_\_\_\_\_\_

Never smoked Yes/No

**SERIOUS ILLNESS, NOW OR IN THE PAST**

|  |  |
| --- | --- |
| **Type of Illness (e.g. diabetes)** | **Approximate date of Onset** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**YOUR MEDICATION, INLCUDING CONTRACEPTIVE PILL**

|  |  |  |
| --- | --- | --- |
| **Name** | **Strength (e.g. 50mg)** | **Frequency (e.g. one a day)** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Any adverse reactions to medicine?**

|  |  |
| --- | --- |
| **Name of Medicine** | **Type of Reaction** |
|  |  |
|  |  |
|  |  |

**DO YOU HAVE PRIVATE HEALTH CARE INSURANCE? YES/NO**

**CARER STATUS**

**Do you care for someone at home but you do not get paid? YES/NO**

**Does someone care for you at home (unpaid)? YES/NO**

FOR OFFICE USE ONLY - IS A CARER CODE 918G HAS A CARER CODE 918F

**Consent Form**

If you would like to consent to a representative receiving test results and messages on your behalf please complete this form to nominate a representative. You do not have to complete this form if you do not wish to nominate a representative.

**Details of Patient**

Name:- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I (name as above) give consent for the below Representative to receive any test result or messages on my behalf.

Please complete the following in capital letters.

**Name of Representative** :- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient** :- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient:- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date signed :- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Vision Online - Patient pre-registration form

If you would like to register for this online service please complete the form below and return it to your practice in person, **along with a valid form of identification, for example photo ID or your passport.**

Once you are registered the practice will give you the information that will enable you to create a username and password.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient details | Please complete in BLOCK CAPITALS | | | | | | | | | | | | | | | | | | | |
| Patient forename |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Patient surname |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Date of birth | D | D | / | M | M | / | Y | Y | Y | Y |  | | | | | | | | | |
| Email address  **This email address will be used by your practice to send you notifications and reminders.** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | | | | | | | | | | | | | | | | | | | |
| Mobile number |  |  |  |  |  |  |  |  |  |  |  |  | | | | | | | | |
| **I CONSENT TO BEING CONTACTED VIA E-MAIL AND MOBILE PHONE e.g Text** | **YES OR NO** (Please circle) | | | | | | | | | | | | | | | | | | | |
| Signature |  | | | | | | | | | | | | | | | | | | | |
| Date | D | D | / | M | M | / | Y | Y | Y | Y |  |  |  |  |  |  |  |  |  |  |
| **Completing the form on behalf of the patient?** | | | | | | | | | | | | | | | | | | | | |
| Print forename |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Print surname |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Relationship to patient |  | | | | | | | | | | | | | | | | | | | |
| Signature |  | | | | | | | | | | | | | | | | | | | |
| Date | D | D | / | M | M | / | Y | Y | Y | Y |  | | | | | | | | | |

-----------------------------------------------------------------------------------------------------------------------------------------

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Staff use only | NEW ONLINE PRESCRIPTION REGISTRATION | | | | | | | | | | |
| Patient ID seen |  | | | | | | | | | | |
| Type of ID |  | | | | | | | | | | |
| Staff name |  | | | | | | | | | | |
| Date | D | D | / | M | M | / | Y | Y | Y | Y |  |