APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE

NHS SCOTLAND

1. PERSONAL DETAILS (ALL FIELDS MARKED * ARE MANDATORY AND MUST BE COMPLETED AS FULLY AS POSSIBLE)

Male* ☐ Female* ☐ 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 ☐
(If 'No', please ask for form GMSTRF001)

Date of Birth* ☐☐ - ☐☐ - ☐☐☐☐

Title*

Surname*

Forenames*

Previous Surname*

email address #

Address*

Postcode* ☐☐☐☐ ☐☐☐

Telephone #

Mobile #

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

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

2. 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:

Enlistment date* ☐☐ - ☐☐ - ☐☐☐☐

Are you a Reservist?* ☐ Yes ☐ No

Leaving date* ☐☐ - ☐☐ - ☐☐☐☐

Is this your first registration with a GP since leaving the Armed Forces?* ☐ Yes ☐ No

Service Number

If yes, please provide your address before enlisting*

Postcode* ☐☐☐☐ ☐☐☐

3. VOLUNTARY CONSENT TO ORGAN DONATION

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death.
Please tick the boxes that apply. Your consent to organ donation will be shared with NHS Blood and Transplant together with the information you have provided in Section 1 including your name, gender, date of birth address and CHI number. For more information on being an organ donor or privacy, please ask for the leaflet on joining the NHS Organ Donor Register or visit www.organdonation.nhs.uk.

Any of my organs and tissue ☐ Or my

Kidneys ☐ Eyes ☐ Heart ☐ Lungs ☐ Liver ☐ Pancreas ☐ Small bowel ☐ Tissue ☐

Patient signature _____ Date ☐☐ - ☐☐ - ☐☐☐☐

4. HOW WE USE YOUR INFORMATION

The information you have provided will be used by the GP Practice 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 cards, 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 make sure that the information which identifies you as a person and your health information are separated or anonymised. Health condition and treatment information which could identify you will not be used for research purposes by the NHS unless you have consented to this.

For more information on how NHS National Services Scotland uses your personal information visit www.nhsnss.org. If you have any queries or concerns about how your personal information is used by the NHS please ask for the leaflet 'Confidentiality – it's your right', visit the Health Rights Information Scotland website at www.hris.org.uk or ask your GP surgery.

NHS National Services Scotland is the common name of the Common Services Agency for the Scottish Health Service.

5. 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, relevant information from this form will be disclosed to the NHS Business Services Authority, NHS National Services Scotland, the Home Office, Identity and Passport Service, HM Revenue and Customs, the General Register Office and Local Authorities.

Patient/Patient's representative signature _____ Date ☐☐-☐☐-☐☐☐☐

Representative's name (if applicable) _____

Relationship to patient (if applicable) _____

6. FOR PRACTICE USE

GP reference number ☐☐☐☐☐☐☐-☐☐ GP name _____

Practice code ☐☐☐☐☐-☐☐ Mileage (No.) Road ☐☐☐☐ Water ☐☐☐☐ Footpath ☐☐☐☐

Identification seen - do not take or retain photocopies

Please initial each relevant box (it is recommended that at least one form of identification is seen to positively identify the applicant)

Birth Cert. ☐ Student ID Card ☐ Driving Licence ☐ Passport or HC2 Cert. ☐ Home Office App Reg Card ☐ Other/None - specify _____ Receptionist initials ☐☐☐

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 ☐☐-☐☐-☐☐☐☐

7. OFFICIAL USE ONLY

Input by _____

Checked by _____

Date ☐☐-☐☐-☐☐☐☐

Practice Stamp

SOUTHBANK SURGERY
NEW PATIENT REGISTRATION

First Name:		**Home Telephone No:**	
Last Name:		**Mobile Telephone No:**	
Date of Birth:	/ /	**Email Address:**	
Ethnicity: **Note: this is a requirement by the Health Board**	See Attached Form	**Next of Kin:** **Name:** **Relationship:** **Contact Number:**	
Do you regularly care for someone who is disabled or chronically ill?		**YES / NO**	
Is the person registering at the practice housebound?		**YES / NO**	

LIFESTYLE:

Current Smoker:	**YES/NO**	**Amount Smoked**	_____ per day
Ex-Smoker:	**YES/NO**	**Date stopped smoking:**	/ /
Never Smoked	**YES/NO**	**Alcohol Consumption:**	_____ units/week

CHRONIC ILLNESSES
Does the person registering have any of the following conditions?

Condition:		Condition:	
Hypertension/High blood pressure	**YES/NO**	**Asthma**	**YES/NO**
Stroke disease/TIA	**YES/NO**	**COPD/ Chronic Bronchiectasis**	**YES/NO**
Ischaemic Heart Disease/ Angina	**YES/NO**	**Epilepsy**	**YES/NO**
Myocardial infarction/heart attack	**YES/NO**	**Heart Failure**	**YES/NO**
Type I Diabetes	**YES/NO**	**Dementia**	**YES/NO**
Type II Diabetes	**YES/NO**	**Mental health illness**	**YES/NO**

ALLERGIES
Does the person registering have any allergies? Please list below

PLEASE LIST ALL MEDICAL CONDITIONS AND MEDICATIONS

An example has been provided.

Condition	Year diagnosed	Medication:	Strength:	Dose:
Eg. Hypertension	2010	Ramipril	10mg	Once daily
		Amlodipine	5mg	Once daily

Office Use: Workflow to Computer and pass paper copy to Registration

SOUTHBANK SURGERY
NEW PATIENT REGISTRATION

PAGE 2 - ETHNIC GROUP

Name: _____ **Date of Birth:** _____

A. White

- ○ Scottish (9S13)
- ○ Other British (9S14)
- ○ Irish (9S11)
- ○ Any other White background (9S12) - (specify) _____

B. Mixed

- ○ Any mixed background (9SB) - (specify) _____

C. Asian, Asian Scottish, Asian British

- ○ Indian (9S6)
- ○ Pakistani (9S7)
- ○ Bangladeshi (9S8)
- ○ Chinese (9S9)
- ○ Any other Asian background (9SH) - (specify) _____

D. Black, Black Scottish or Black British

- ○ Caribbean (9S2)
- ○ African (9S3)
- ○ Any other Black background (9SG) – (specify) _____

E. Other ethnic Background

- ○ Any other background (9SJ) - (specify) _____

F. Other

- ○ Prefer not to say (9SD)