APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE

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

NHS SCOTLAND

1. 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 ◯

(If 'No', please complete a temporary resident form)

Male * ☐ Female * ◯

Date of birth *

Title *

Surname *

Forenames *

Previous surname *

Address *

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

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:

Service Number

Enlistment date *

Are you a Reservist? Yes ☐ No ◯

Leaving date *

If yes provide your address before enlisting *

Postcode *

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

3. 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

4. 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 Services Scotland (the 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.

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, 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

Date *

Representative's name (if applicable)

Relationship to patient (if applicable)

6. 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 *

7. FOR OFFICIAL USE ONLY

Input by

Checked by

Date

Practice stamp

NAME _____ DOB _____

ADDRESS _____ TEL NO _____

NEXT OF KIN NAME & TEL NO _____

FAMILY CIRCUMSTANCES (please circle) -

MARRIED SINGLE DIVORCED NO. OF DEPENDANTS _____

DO YOU SUFFER FROM -

Asthma	Y / N	Diabetes	Y / N	High Blood Pressure	Y / N
Heart Condition	Y / N	Stroke	Y / N	Epilepsy	Y / N
Multiple Sclerosis	Y / N	Rheumatoid Arthritis	Y / N	Depression / Anxiety	Y / N
Any other illness	Y / N				

ARE YOU TAKING ANY MEDICATION Y / N
(if yes please list names of medicines) _____

_____

DO YOU SUFFER FORM ANY ALLERGIES Y / N
(if yes please list) _____

_____

FAMILY HISTORY (hereditary conditions)

Diabetes Y / N Heart Disease Y / N Epilepsy Y / N Asthma / eczema Y / N
Any other Y / N

SCREENING EXAMINATIONS
Last Cervical Smear date _____

HAVE YOU EVER HAD AN OPERATION (please state) _____

OCCUPATION _____

ARE YOU AN UNPAID CARER OR DO YOU HAVE A CARER? Y / N
If yes please give name and tel. no. _____

LIFESTYLE

Smoking Y / N If yes, would you like referred on for help to stop smoking? Y / N If yes, please ask at reception

Alcohol units per week _____

ETHNIC GROUP PLEASE CIRCLE ONE -

WHITE 9S1	WHITE BRITISH 9S10	OTHER WHITE ETHNIC GROUP 9S12
WHITE SCOTTISH 9S15	OTHER WHITE BRITISH ETHNIC GROUP 9S14	WHITE IRISH 9S11
BLACK CARIBBEAN 9S2	BLACK AFRICAN 9S3	BLACK OTHER NON MIXED S94
BLACK BRITISH 9S4	BLACK OTHER ASIAN 9S47	BLACK OTHER MIXED 9S5
INDIAN 9S6	PAKISTAN 9S7	BANGLADESHI 9S8
CHINESE 9S9	OTHER EUROPEAN 9SAC	ETHNIC GROUP PATIENT REFUSED 9SD

WE ADVISE THAT YOU MAKE AN APPOINTMENT WITH THE PRACTICE NURSE FOR FURTHER HEALTH SCREENING