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 ☐☐ - ☐☐ - ☐☐☐☐

MORAY COAST MEDICAL PRACTICE - NEW PATIENT QUESTIONNAIRE

*Please complete in full **ALL** of the "**Application to Register with a Medical Practitioner**" form that has been given to you **AND ALL** the sections that relate to you on this form. We may not be able to properly register you on our system or trace your previous medical records without all the necessary information.*

Patient Details			
Full Name		Date of Birth	
Address		Marital Status	
		Home Tel No	
		Mobile Tel No	
Previous Surname(s)		Male or Female	

Which ethnic group do you belong to? *Please tick*

A. White
- ☐Scottish
- ☐English
- ☐Welsh
- ☐Northern Irish
- ☐British
- ☐Irish
- ☐Gypsy / traveller
- ☐Polish
- ☐Any other white ethnic group

B. Mixed or multiple ethnic groups
- ☐Any mixed or multiple ethnic group

F. ☐I do not wish to give this information

C. Asian, Asian Scottish or Asian British
- ☐Pakistani, Pakistani Scottish or Pakistani British
- ☐Indian, Indian Scottish or Indian British
- ☐Bangladeshi, Bangladeshi Scottish or Bangladeshi British
- ☐Chinese, Chinese Scottish or Chinese British
- ☐Any other Asian background

D. African, Caribbean or Black
- ☐African, African Scottish or African British
- ☐Caribbean, Caribbean Scottish or Caribbean British
- ☐Black, Black Scottish or Black British
- ☐Other black background

E. Other ethnic group
- ☐Arab
- ☐Other

Do you require the services of an interpreter? ..... **If yes, please state language used**.....

Do you require the services of sign language? ..... **Do you require Makaton sign language?** .....

Any known allergies:	
Current Medication: If you have a current repeat medication request form from your previous practice, please attach it to this form. **Please note that you will need to make an appointment with a GP to receive your first repeat prescription – thereafter items may be ordered using the repeat prescription service.**	

Previous Medical History – Chronic Illnesses				
Hypertension:	Yes / No		Asthma	Yes / No
CHD (Coronary Heart Disease):	Yes / No		Stroke:	Yes / No
Diabetes:	Yes / No		Epilepsy:	Yes / No
Heart Failure:	Yes / No		Mental Health:	Yes / No
Cancer (please specify):.....	Yes / No		Dementia:	Yes / No
CKD (Chronic Kidney Disease):	Yes / No		COPD:	

Smoking Status / Alcohol Consumption

Smoking - Please circle:
Smoker (how many per day? .....) / **Ex-Smoker** (Date started..... / Date stopped.....) / **Never Smoked**

Alcohol - Please circle:
Currently Drinks (how may units per week.....?) / **Lifetime Teetotaler** / **Ex-Drinker** (Date started..... / Date stopped.....)

Ex-Service / Dependant – Additional Details Required	
Name and Address of last **civilian** doctor:	
Last residential address **before joining Service:**	

Under 14s – Additional Details Required	
Name of Parent / Guardian:	

We are currently considering sending out text messages to inform / remind patients of their appointments (please ensure you have entered your mobile telephone number above):
I wish to receive FREE text appointments notifications / reminders: YES / NO
(you may opt out of this service at any time by contacting the surgery). Signed:.....

Two items of proof of identity MUST accompany this form. At least one of these should be photographic (i.e. Passport, Driving Licence, Identity Card – please note Bank / Visa Cards are not acceptable).