# 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

**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

**F. ☐I do not wish to give this information**

**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:<br>If you have a current repeat medication request form from your previous practice, please attach it to this form.<br>**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 | | CHD (Coronary Heart Disease): | Yes / No |
| Asthma / COPD: | Yes / No | | Stroke: | Yes / No |
| Diabetes: | Yes / No | | Epilepsy: | Yes / No |
| Heart Failure: | Yes / No | | Mental Health: | Yes / No |
| Cancer: | Yes / No | | Dementia: | Yes / No |
| CKD (Chronic Kidney Disease): | Yes / No | | | |

| **Smoking Status / Alcohol Consumption** | | |
|---|---|---|
| Smoker (please circle): | Yes / No | If yes, how many per day?: |
| Alcohol Consumption: | | How many units per week?: |

| **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: | |

**Two items for proof of identity need to be produced to accompany this form. At lease one of these should be photographic (i.e. Passport, Driving Licence, Identity Card – Please note Bank/Visa Cards are <u>not</u> acceptable).**

# GPR

NHS IN SCOTLAND

## APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE

Please use **BLOCK CAPITALS** to complete the form and tick all relevant boxes

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

Eligibility to use the NHS services depends mainly on residence in the UK, and on other qualifying provisions set out in the Regulations. By completing this section fully, you will assist us in processing your application and locating any existing medical records promptly.

WILL YOU BE IN THE AREA FOR MORE THAN THREE MONTHS?* YES ☐ NO ☐

IS THIS YOUR FIRST REGISTRATION WITH A GP PRACTICE?* YES ☐ NO ☐

SURNAME *

TITLE #

MALE * ☐ FEMALE * ☐

FORENAME *

MIDDLE NAME *

PREVIOUS SURNAME *

DATE OF BIRTH * D D M M Y Y Y Y

ADDRESS *

POSTCODE *

TOWN & COUNTRY OF BIRTH *

MOTHER'S MAIDEN NAME *

TELEPHONE NUMBER #

EMAIL ADDRESS #

PREVIOUS ADDRESS IN UK *

POSTCODE

NAME AND ADDRESS OF PREVIOUS REGISTERED GP PRACTICE IN UK *

POSTCODE *

COMMUNITY HEALTH INDEX NUMBER

NHS NUMBER

NATIONAL INSURANCE NUMBER

# 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.

ARE YOU RETURNING / HAVE YOU ARRIVED FROM ABROAD OR HM FORCES? * YES ☐ NO ☐

DATE OF DEPARTURE FROM UK D D M M Y Y

DATE OF ENTRY/RETURN TO UK D D M M Y Y

IF RETURNING FROM H M FORCES DATE ENLISTED D D M M Y Y

SERVICE/PERSONNEL NO.

## COUNTER FRAUD 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 the Common Services Agency to confirm my eligibility to lawfully register with a GP and for the purposes of prevention, detection, and investigation of crime, I consent to the disclosure of relevant information from this form including to and by the NHS Business Services Authority, the Common Services Agency, UK Border Agency, Identity and Passport Service, the Department for Work & Pensions, HM Revenue and Customs, the General Register Office and Local Authorities.

PATIENT OR REPRESENTATIVE SIGNATURE

_____ DATE D D M M Y Y

IF SIGNING AS A REPRESENTATIVE, PLEASE STATE:

YOUR NAME

YOUR RELATIONSHIP TO THE PATIENT

## VOLUNTARY CONSENT TO ORGAN DONATION

**I authorise the donation of** (Please tick the boxes that apply)

A. any of my organs and tissue ☐ or my

B. kidneys ☐ heart ☐ liver ☐ small bowel ☐

eyes ☐ lungs ☐ pancreas ☐ tissue ☐

**for transplantation after my death** D D M M Y Y

PATIENT SIGNATURE _____ DATE

## PRACTICE ACCEPTANCE AGREEMENT – for GP Practice use only

PRACTICE CODE

GP NAME

GP REFERENCE NUMBER

IDENTIFICATION SEEN

MEDICAL CARD ☐ BIRTH CERTIFICATE ☐ PASSPORT ☐ OTHER - SPECIFY

I accept this patient onto the practice list and declare that, to the best of my knowledge the information I have given on this form is correct and complete and I understand that if it is not, action may be taken against me. I acknowledge that the details may be authenticated from appropriate records, and that payments generated from this patient registration will be made to my Practice, which will be subject to Payment Verification. Where Common Services Agency is unable to obtain authentication, I acknowledge that the onus is on my Practice to provide documentary evidence to support this application.

GP SIGNATURE _____ DATE D D M M Y Y

| OFFICIAL USE ONLY | | |
|---|---|---|
| Input By: | Date: | Checked By: |