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

Atholl Medical Centre – Consent Form

Created May 2018
Updated January 2022

Full Name:_____

Date of Birth:_____

The contact information you have provided will only be used by the GP Practice to get in touch with you regarding your healthcare. We do however require your consent for keeping your data for these purposes. Please complete each line below by circling the relevant option then sign your name in the space provided.

I consent / do not consent to the surgery using my address and email address for general correspondence related to my healthcare.

Signed.....

I consent / do not consent to the surgery using my Mobile phone number and or email address for the purpose of sending appointment reminders.

Signed.....

I consent / do not consent to the surgery using my Home and or Mobile number for the purpose of contacting me regarding Test results, GP telephone consultations and medical matters requiring resolution sooner than mail correspondence would provide.

Signed.....

The surgery sometimes opts into University led disease research projects which require patient participation. I consent / do not consent to being contacted by researchers solely for the purpose of them explaining a research project and requesting my consent for participation in the project.

Signed.....

My next of kin choice has consented for me to provide their contact info to the Surgery.

Signed.....

This consent document will be filed in your medical record. You can change your consent choices at anytime.

PLEASE FILL IN THIS QUESTIONNAIRE AND HAND IT IN WITH YOUR REGISTRATION FORM

NEW PATIENT QUESTIONNAIRE

First Name		**Last Name**	
Date of Birth	DD MM YY	**Occupation**	
Next of Kin	NAME AND RELATIONSHIP TO YOU	**Next of Kin Contact No.**	

Your Health:

Do you smoke?

Yes ☐ **How many a day?** __ __

No ☐

Previously ☐ **What year did you stop?** __ __ __ __

Do you drink alcohol?

Yes ☐ **How much/How often?** __ __ __ __ __ __ __ __ __ __ __ __

No ☐

Have you had any serious illness or condition in the past?

Yes ☐ **Please specify what/when:** __ __ __ __ __ __ __ __ __ __ __ __

No ☐ __

Is there any family history of: Diabetes / Asthma / Heart Disease / High Blood Pressure / Stroke / Cancer / Other

Yes ☐ **Please specify what:** __ __ __ __ __ __ __ __ __ __ __ __

No ☐

If you ticked Yes, please tell us the relationship to you and at what age your relation contracted this if known:

__ __

FOR WOMEN ONLY

Date of your last smear test if known: __ __ __ __ __ __

Have you had a hysterectomy?

Yes ☐

No ☐

ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with early identifications of some of these conditions.

Choose **one** section from A to E and then tick **one** box to indicate your background.

A – White

- ☐ **Scottish**
- ☐ **Other British**
- ☐ **Irish**
- ☐ **Any other white background; please specify**

B – Mixed

- ☐ **White and Black Caribbean**
- ☐ **White and Black African**
- ☐ **White and Asian**
- ☐ **Any other mixed background; please specify**

C – Asian or British Asian

- ☐ **Indian**
- ☐ **Pakistani**
- ☐ **Bangladeshi**
- ☐ **Any other Asian background; please specify**

D – Black or Black British

- ☐ **Caribbean**
- ☐ **African**
- ☐ **Any other black background; please specify**

E – Chinese or Other ethnic group

- ☐ **Chinese**
- ☐ **Any other ethnic group; please specify**

patient services

Patient Services - Patient 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	
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	
Patient ID seen	
Type of ID	