

# APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE

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



## 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 \*

Email address #

Address \*

Postcode \*

Telephone #

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

If yes provide your address before enlisting \*

Leaving date \*

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](http://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	<input type="text"/>	Date *	<input type="text"/>
Representative's name (if applicable)	<input type="text"/>		
Relationship to patient (if applicable)	<input type="text"/>		

### 6. FOR PRACTICE USE

GP reference number	<input type="text"/>	GP name	<input type="text"/>
Practice code	<input type="text"/>		

#### 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 <input type="checkbox"/>	Student ID card <input type="checkbox"/>	Driving licence <input type="checkbox"/>	Passport or HC2 cert <input type="checkbox"/>	Home Office app reg card <input type="checkbox"/>	Other / None <input type="text"/>
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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	<input type="text"/>	Date *	<input type="text"/>
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### 7. FOR OFFICIAL USE ONLY

Input by	<input type="text"/>	<input type="text"/>
Checked by	<input type="text"/>	
Date	<input type="text"/>	

# Atholl Medical Centre

## New Patient Questionnaire For Children Under 16

**PATIENT NAME**

**DATE OF BIRTH**

DD MM YY

### Your Child's Health:

**Is your child currently in good health?**

No  Please specify what:

Yes

**Is your child currently taking any medication?**

Yes  Please specify what:

No

**Has your child 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

No

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

### Immunisations

**Has your child received the following immunisations? If known, please give the dates of immunisations and score out any immunisations not received.**

	1st	2nd	3rd
Diphtheria, Tetanus, Whooping Cough			
Polio			
HIB			
Meningitis			
MMR (aged 12-15months)			
	<b>Pre-School Booster</b>	<b>Booster</b>	<b>Booster</b>
Diphtheria and Tetanus			
Polio			
MMR			

## 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.

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### **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

# Atholl Medical Centre

## Consent Form

**PATIENT NAME**

**DATE OF BIRTH**

DD MM YY

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**

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