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 #

Mobile #

Email address #

 # 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

MUIREDGE SURGERY

New Patient Medical Questionnaire

In order to ensure your registration is processed correctly, please answer all questions below.

FULL NAME: _____

ADDRESS: _____

_____ POSTCODE: _____

MOBILE: _____ HOME: _____

EMAIL: _____

DATE OF BIRTH: ____/____/_____

NEXT OF KIN: _____RELATIONSHIP TO PATIENT_____

CONTACT DETAILS: _____

CLINICAL INFORMATION

Please answer the following questions (tick each appropriate answer):

I currently smoke and would like to be referred for smoking cessation advice	[ ]
I currently smoke and do not wish to be referred for smoking cessation advice	[ ]
I am an ex smoker	[ ]
I have never smoked	[ ]
I currently use a vape/e cigarette (advice re stopping 0800 025 3000)	[ ]
I am ex vape/e cigarette user	[ ]

How many units of alcohol do you drink per week? _____

Are you allergic to anything (if yes, please provide details) _____

Are you currently on repeat medication (if yes, please provide details)

_____

_____

_____

Which Pharmacy would you like your prescriptions to be sent to (please circle):

Boots Buckhaven	Wemyss Pharmacy	Omnicare Methil	Well Pharmacy	Kennoway
Boots Methil	Boots Leven	Omnicare Leven	Leven Pharmacy	

Do you suffer from any of the following (please circle):

Diabetes / Coronary Heart Disease / Asthma / Stroke / COPD / High Blood Pressure / Cancer / Epilepsy

Thyroid Problems / Dementia / Mental Health Problems / Kidney Problems

Please provide details regarding your past medical history such as operations or serious illness:

_____

_____

Females Only:

Have you attended for a cervical screening appointment in the past 5 years? YES / NO

If yes, approximately when did you attend for this (month and year)? _____

Patient Signature: _____ Date: _____

Patient Ethnic Origin Questionnaire

Please indicate your ethnic origin

Choose ONE section then tick the most appropriate box

Name.....

Date of Birth.....

White

	British
	Irish
	Any other White background please write below

Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other Mixed background please write below

Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background please write below

Black or Black British

	Caribbean
	African
	Any other Black background please write below

Chinese or other ethnic group

	Chinese
	Any other please write below

Declined	

First Language	