

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 *

Address *

Title *

Surname *

Forenames *

Previous surname *

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 *

Name and address of previous GP Practice in UK *

Postcode *

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

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

FAMILY HISTORY

Please let us know of any relatives that suffer from the following conditions – Asthma, Cancer, COPD, Diabetes, Epilepsy, Heart Disease, Hypertension, Mental Health issues, Stroke, Thyroid problems

RELATION	DETAILS

Do you smoke? Never smoked? Ex Smoker, for how many years?
 How much alcohol do you drink per week?

ALLERGIES

Do you have any allergies? YES/NO

If YES, please give details

IMMUNISATIONS - Are you currently protected against:

Tetanus YES/NO Date of last booster Polio YES/NO Date of last booster

CHILDREN ONLY

Please bring your child’s Red Book so we can take a copy of your childs immunisation record

FEMALES ONLY

Have you had a cervical smear? YES/NO If YES, date of most recent smear

How many pregnancies have you had?

How many of these have ended in abortion or miscarriage?

What method of contraception are you using (if any)?

Is there anything else, not mentioned above, in your health or that of your family, which may be relevant?

Please complete if you wish to authorise someone to handle matters on your behalf

I authorise

Address ..

Date of Birth

To handle matters on my behalf regarding:
 (Please select which you wish dealt with by the above person)

Appointments

Results

Medication

Discussion with Doctors/Nurses regarding my care

Signature Date



**33 - 37 Castle Street
Dumfries DG1 1DL**

tel 01387 257752 fax 01387 257020

Website: www.greyfriarsmedicalcentre.scot.nhs.uk

Email: dg.gpclinic@nhs.scot

GREYFRIARS

MEDICAL CENTRE

This questionnaire will give Staff some basic information about your Communication support needs and ethnicity to support your health care.

We should be grateful if you could complete one for each family member within the practice.

Name..... DOB __ / __ / __

Do you need an interpreter? Yes/No or sign language support? Yes/No (delete as appropriate)

If you do need an interpreter what language do you speak? Please state

What is your ethnic group?

Choose ONE section from A to E then tick ONE box which best describes your ethnic group or background

A White -

- Scottish
- English
- Welsh
- Northern Irish
- British
- Irish
- Gypsy/Traveller
- Polish

Any other white ethnic group, please write in

B Mixed or multiple ethnic groups -

- Any mixed or multiple ethnic groups

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
- Other, please write in.....

D African, Caribbean or Black -

- African, African Scottish or African British
- Caribbean, Caribbean Scottish or Caribbean British
- Black, Black Scottish or Black British
- Other, please write in.....

E Other ethnic group -

- Arab
- Other, please write in.....

If you do not wish to give this information, please tick here