21/03/2022

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 ☐

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 ☐

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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

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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 No.	
Previous Surname(s):		Male or Female:	

Which ethnic group do you belong to? Please Tick one of the following:

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

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 Drug Allergies:	**Yes/No**		
If yes, please list the drugs and your reaction:			
Please list your current repeat medication, or attach a recent repeat/ re-order slip. **Please note, we will be in contact with your previous GP to request a summary.**			
Would you like to collect your medication from a chemist?	**Yes/No**	**Boots High St**	**Boots Edgar Rd**
If you circle YES, please select a chemist. If you circle NO, your medication will remain at the Surgery for collection.	**Boots L/wood**	**Lloyds W/E**	**Lloyds E/E**
	Lloyds Lossie	**Lossie Pharm**	**Lhanbryde**
	Duthies B/head	**Duthies H/man**	
	Bishopmill	**Other please specify:**	

Previous Medical History - Chronic Illnesses (Not your family history)			
Hypertension:	YES/NO	**Asthma:**	YES/NO
CHD (Coronary Heart Disease):	YES/NO	**Stroke:**	YES/NO
Diabetes:	YES/NO	**Epilepsy:**	YES/NO
Heart Failure:	YES/NO	**Mental Health:**	YES/NO
Cancer (please specify).........................	YES/NO	**Dementia:**	YES/NO
CKD (Chronic Kidney Disease)	YES/NO	**COPD:**	YES/NO

Please turn over to complete the rest of this form, if it is not completed fully, we will hand it back to you.

Thank you

Smoking Status/Alcohol Consumption		
Smoking - please circle **Smoker** **(How many per day?..................)**	**Ex-Smoker** **(Date Started............./ Date Stopped..............)**	**Never Smoked**
Alcohol - please circle **Currently Drinks** **(How many units per week?.........)**	**Ex-Drinker** **(Date Started............./ Date Stopped..............)**	**Lifetime Teetotaler**

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	

We currently use a text messaging system to inform/remind patients of their appointments (please ensure you have entered your mobile number above). Anyone over the age of 14, must use their own contact details unless written consent is provided to state the parent/guardians number can be used.

I wish to receive FREE text appointment notifications/reminders: YES/NO

(you may opt of this service at any time by contacting the Surgery). **Signed:**..

Please note, we may request two items of proof of identity. At least one of these should be photographic (i.e. Passport, Driving Licence, Identity card. – Please note that Bank statements/cards will NOT be accepted.)

NOK Information			
Full Name:	**Relation to you:**	**Address:**	**Contact numbers:**

Please tick the box if you give permission for us to contact your next of kin in the case of an emergency. ☐

Please be aware that we cannot disclose any information about you or your medical record to family or friends. We must gain your consent in writing before we can disclose any information and would suggest that this is provided at registration if someone regularly deals with matters on your behalf. If you have a Power of Attorney, please bring in the paper work so we may add a copy to your record.

We may need to contact your previous surgery to get a short summary of your record so we may ensure you receive the best possible care. Some Practices ask that we provide written consent from the patient to ensure they are not providing information without your prior knowledge. Please tick one of the options below.

☐ I.. (Full Name) give consent for Moray Coast Medical Practice to request a patient summary

☐ I..(Full Name) do not give consent for Moray Coast Medical Practice to request a patient summary

Patients Signature:.. Date:.................................