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 *

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

THE HOPETOUN PRACTICE
NEW PATIENT QUESTIONNAIRE

Name: ……..

Address: ……..

Town: ……..

Postcode: ……

Occupation: ……..

Marital Status: ……..…….

Date of Birth: ……..……...

Home Tel No: ……..……..

Mobile No: ……...……..

Height: ……..…….

Weight: ……..…

Next of Kin details

Their Name ……

Relationship to you: ……

Their Contact No:……..

Are you an unpaid carer? Y/N

Do you rely on an unpaid carer? Y/N

Do you smoke? (Please circle) Yes If Yes, how many per day? ……..

No If No, please underline one of the following options:

Never Smoked **Given up smoking in the last year** **Not smoked for more than a year**

Do you drink Alcohol? (Please circle) Yes If so, how many units per week? ……..

No

IF YOU WERE BORN BEFORE 1996: Do you think you may have had a blood transfusion? Y/N

Do you suffer from any of the following conditions? (Please circle)

			Date/Age Diagnosed
High blood pressure	Yes	No	……..
Ischaemic or coronary heart disease	Yes	No	…….
Stroke or any weakness down on side	Yes	No	…….
Diabetes	Yes	No	…….
Asthma/Chronic Bronchitis/Emphysema (COPD)	Yes	No	…….
Mental health problems	Yes	No	…….
Thyroid problems	Yes	No	……..
Epilepsy	Yes	No	……..
Cancer	Yes	No	……..

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Have any of your family (Mother, Father, Brother, Sister) been diagnosed with any of the illnesses overleaf?

If so, please provide details …….

……..

……..

Do you have a history of any of the following? If so, please provide details

Serious Illness: ……

Serious Accident: ……

Operations: ……..

Allergies ……..

Adverse reaction to drug or treatment: ……...

Are you on any medication at present? If so, please provide details (PLEASE NOTE: You will need to provide proof of medications and book in to speak to a clinician before we can issue your first prescription. Proof can either be a printed summary sheet, which you can request from your previous Practice, or a copy of your prescription re-order form. If you place an order on our website for something that we have never prescribed for you, this request will be automatically rejected)

……..

……..

If known, please provide date of last Tetanus vaccination: Date…….

If known, please provide date of last Polio vaccination: Date…….

FEMALE PATIENTS ONLY

Have you had a smear test carried out recently? Yes No
(Please circle)

Where was the test performed? ……...

Date? ……...

Was the result normal? (Please circle) Yes No

Have you had breast screening carried out? Yes No
(Please circle)

When was your last Rubella vaccination? Date…….

If you would like an appointment to see the Practice Nurse for a health check (height, weight, BP) please ask at Reception.

The Hopetoun Practice
REGISTRATION QUESTIONS

Title Miss/Mrs/Mr: _____ Marital Status: _____

Occupation: _____

Tel No: _____

We have been asked by the Government to record the ethnic origin of all our patients and would be grateful if you could take the time to complete this short form. If you would like further information, please ask the receptionist for the leaflet entitled "Ethnicity Questionnaire"

What is your ethnic group?

Choose ONE section from A to E, and tick the appropriate box to indicate your cultural background.

If you do not wish to answer this question, please tick this box - ☐

A **White**

- ☐ British
- ☐ Irish
- ☐ Any other White background, please write in

B **Mixed**

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other Mixed background, please write in

C **Asian or Asian British**

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Any other Asian background, please write in

D **Black or Black British**

- ☐ Caribbean
- ☐ African
- ☐ Any other Black background, please write in

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Chinese or other ethnic group

E

- ☐ Chinese
- ☐ Any other background, please write in _____

What is your first/preferred language? _____

Do require assistance from an interpreter YES/NO

If YES which language_____

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Text Message Consent Form

The Practice offers a text-messaging service which is linked to your registered mobile phone number. Examples of things it can be useful for include:

1. to send appointment reminders, 24 hours before a scheduled face-to-face appointment with any member of the Practice team.
2. to send general information during or after a consultation, such as a website link.
3. to ask you to call the surgery if we need to discuss something with you.
4. with your express permission, to use the service to send you more sensitive medical information, such as test results, instructions about medication, or short messages about your medical condition.

If you would like to make use of our text-messaging service for purposes mentioned in Options 1 to 3 above, please complete this consent form.

Due to the confidential nature of the types of information mentioned in Option 4 above, if you would also like us to use our text-messaging service for those purposes, we require your separate, explicit, consent to do so. You will be unable to submit the consent form if do not answer that question.

- ## Your Details

  Full Name

  Date of Birth

  Mobile Number

  I consent to the Practice contacting me by text message for such purposes as described in Options 1 to 3 above.

  Yes

  No

  I consent to the Practice using its text-messaging service to send me confidential information, such as that described in Option 4 above.

  Yes

  No

  THIS FORM COLLECTS YOUR NAME, DATE OF BIRTH, EMAIL, OTHER PERSONAL INFORMATION. THIS IS TO CONFIRM YOU ARE REGISTERED WITH THE PRACTICE, TO ALLOW THE PRACTICE TEAM TO CONTACT YOU.

PLEASE READ OUR PRIVACY POLICY TO DISCOVER HOW WE PROTECT AND MANAGE YOUR SUBMITTED DATA.

I consent to the Practice collecting and storing my data from this form.

Signature

Date