APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE

1. PERSONAL DETAILS (ALL FIELDS MARKED * ARE MANDATORY AND MUST BE COMPLETED AS FULLY AS POSSIBLE)

Male*		Female*		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 ask for from GMSTRF001 (Temp Resident)					

Date of birth*		Address*	
Title*			
Surname*		Postcode*	
Forenames*		Telephone #	
Previous Surname*		Mobile #	
Email address #			

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	

The data supplied in these fields will not be input to, or updated in, the CHI, but will be held on the GP Practice's system

2. HELP US TO TRACE YOUR PREVIOUS GP HEALTH RECORDS BY PROVIDING THE FOLLOWING INFORMATION

Address in the UK when you were last registered with a GP*		Name and address of previous GP Practice in the 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:

Enlistment date*					Service Number	
Are you a Reservist?*	Yes		No		If yes, please provide your address before enlisting*	
Leaving date*						
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.

4. HOW WE USE YOUR INFORMATION

The information you have provided will be used by the GP Practice 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 will be used to register you with the GP Practice, transfer your medical records between GP Practices for medical services provided, and to process and issue medical cards, medical exemption certificates and entitlement cards.

NHS National Services Scotland shares information with you within NHS Scotland to assist in the provision and improvement or NHS services and the health of the public. When we do this, we make sure that the information which identifies you as a person and your health information are separated and anonymised. Health condition and treatment information which could identify you will not be used for research purposes by the NHS unless you have consented to this.

For more information on how NHS Services Scotland uses your personal information visit www.nhsnss.org. If you have any queries or concerns about how your personal information is used by the NHS please ask for the leaflet 'Confidentiality – it's your right', visit the Health Rights Information Scotland website at www.hris.org.uk or ask your GP surgery.

NHS National Services Scotland is the common name of the Common Services Agency for the Scottish Health Service.

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, relevant information form this form will be disclosed to the NHS Business Services Authority, NHS National Services Scotland, the Home Office, Identity and Passport Service, HM Revenue and Customs, the General Register Office and Local Authorities.

Patient / Patient's representative signature		Date	
Representative's name (if applicable)			
Relationship to patient (if applicable)			

New Dyce Medical Practice

6. FOR PRACTICE USE

GP Reference number		GP name							
Practice code		Mileage (No.)	Road		Water		Footpath		

Identification seen – do not take or retain photocopies

Please initial each relevant box (it is recommended that at least one form of identification is seen positively to identify the applicant)

Birth Cert		Student ID		Driving licence		Passport or HC2 Cert		Home Office App Reg Card		Other/None - specify	

Receptionist initials		

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. OFFICIAL USE ONLY

Input by		Practice Stamp	
Checked by			
Date			

New Dyce Medical Practice

New Patient Questionnaire

Surname: _____ Forename/s: _____

Date of Birth: _____ Maiden Name: _____

Work Tel: _____ Mobile Tel: _____

Home Tel: _____ Marital Status: _____

Occupation: _____

Name of Emergency Contact: _____ Relationship to you: _____

Emergency Contact Daytime Tel: _____

Emergency Contact Evening Tel: _____

Emergency Contact Email: _____

OTHER PEOPLE WHO LIVE AT THE SAME ADDRESS

Name	Date of Birth	Relationship to you

ETHNIC ORIGIN

Please tick the appropriate box – of the last box if you do not wish to give this information

9S13 White Scottish		9S6 Indian	
9S14 Other White British		9S7 Pakistani	
9S11 White Irish		9SB Bangladeshi	
9S12 Other White Ethnic		9S9 Chinese	
9SB Other Ethnic Mixed Origin		9SH Other Asian Ethnic Group	
9S2 Black Caribbean		9SJ Other Ethnic Group (please specify)	
9S3 Black African			
9SG Other Black Ethnic Group		9SD Ethnic Group Refused	

FAMILY HISTORY: Please tell us about serious illnesses in your family (especially heart disease, strokes, cancer, asthma, diabetes and glaucoma):

	Age	Illness	Age of Onset	Age of Death	Cause of Death
Father					
Mother					
Other Family					

If you need to see a GP or nurse, please bring all medications that you are taking to your first appointment.

Height: _____ Weight: _____

ALCOHOL STATUS

Usual type of alcohol: _____

Units per day: _____

One unit is about ½ a pint of beer, one pub measure of spirits of a glass of wine

New Dyce Medical Practice

SMOKING STATUS – are you? (please circle one)

A smoker Yes / No Type + how many per day? _____

An ex-smoker Yes / No If so, when did you stop? _____

Never smoked Yes / No

SERIOUS ILLNESS (CURRENT OR PAST)

Type of illness (e.g. diabetes type 2)	Approximate date of onset

YOUR MEDICATION (INCLUDING CONTRACEPTIVES)

Name	Strength (e.g. 50mg)	Frequency (e.g. one per day)

Please continue onto another sheet if necessary and attach to this form

ALLERGIES (INCLUDING ADVERSE REACTIONS TO MEDICINES)

Name of Medicine	Type of Reaction

DO YOU HAVE PRIVATE HEALTH CARE INSURANCE? YES / NO

CARER STATUS

Do you care for someone at home (unpaid)? YES / NO

Does someone care for you at home (unpaid)? YES / NO

FOR OFFICE USE ONLY IS A CARER: CODE 918G

HAS A CARER: CODE 918F

New Dyce Medical Practice

GENERAL DATA PROTECTION REGULATION

In line with General Data Protection Regulations we cannot discuss or share information regarding your medical wellbeing with your relatives, partner or carer without your prior consent. If you agree to this information being shared with these individuals please give your consent below. **I,**

Name: _____ Date of Birth: _____

Address: _____

_____

Home Tel: _____ Mobile Tel: _____

Work Tel: _____

Email Address: _____

consent to information from my medical records at New Dyce Medical Practice being shared with the undernoted people. This information may include my test results and messages regarding future appointments at the practice.

Name: _____ Date of Birth: _____

Relationship to you: Relative ☐ Partner ☐ Carer ☐ Other (please specify) _____

Name: _____ Date of Birth: _____

Relationship to you: Relative ☐ Partner ☐ Carer ☐ Other (please specify) _____

I consent to the following methods being used to contact me (please tick box)

Home Tel	☐	Mobile Tel	☐	Work Tel	☐
Text msg	☐	Letter	☐	Email	☐

I also consent to you identifying yourself as New Dyce Medical Practice when you leave a message via the above selected method/s.

YES ☐ NO ☐

Please note: If you do not respond to our messages left via your preferred method, we will automatically default to sending you a letter on our third attempt.

Patient Signature: _____

If your personal circumstances change and you no longer consent to the above information being shared, please inform the practice as soon as possible.

New Dyce Medical Practice

Vision Online – Patient Pre-Registration Form

If you would like to register for this online service please complete the form below and return it to the practice, along with a valid form of identification, e.g. a driver's licence.
Once you are registered the practice will give you the information that will enable you to create a username and password.

Patient Details	**Please complete in BLOCK CAPITALS**
Patient Forename	
Surname	
Date of Birth	
Email address (this may be used by your practice to send you notifications and reminders)	
Mobile Telephone	
Signature	
Date	

Completing the form on behalf of the patient?	
Your forename	
Your surname	
Relationship to patient	
Signature	
Date	

STAFF USE ONLY	
Patient ID seen?	YES NO
Type of ID	Driver Passport National ID Other:
Staff Name	
Date	