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| **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 NHSScotland 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](http://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](http://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) |  |
|  |
| **6. FOR PRACTICE USE** |
| GP Reference number |  | GP name |  |
| Practice code |  | Mileage (No.) | Road |  | Water |  | Footpath |  |
|  |  |  |  |  |  |  |  |  |
| Identification seen – do not take or retain photocopiesPlease 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 |  |  |

**Registration Details – Child Immunisations**

**To avoid delay please** **print clearly** **and provide all information requested below**.

**Name of Child:** ......................................................................... **Male**  **Female**

**Date of Birth:**  ........................................................... **Date of transfer** .......................................

**New Address:** ................................................................................................................................

 ................................................................................**Postcode**..............................

**Old address:** ..................................................................................................................................

 ........................................................................... **Postcode**...............................

**Previous GP:** .................................................................................................................................

**Previous GP Address:** ........................................................................................................................................

**ETHNIC ORIGIN**

**Please tick the appropriate box – or 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 |  |  9S8 Bangladeshi |  |
| 9S12 Other White Ethnic |  |  9S9 Chinese |  |
| 9SB Other Ethnic Mixed Origin |  |  9SH Other Asian Ethnic Group |  |
| 9S2 Black Caribbean |  |  9SJ Other Ethnic Group |  |
| S3 Black African |  |  |  |
| 9SG Other Black Ethnic Group |  |  9SD Ethnic Group not given-refused |  |

**If you are from outwith Scotland/UK please list below the immunisations that your child has already received:**

|  |  |  |
| --- | --- | --- |
| **Date given:** | **Type of Immunisation:** | **Where given:** |
|  |  |  |
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**SIGNED**......................................................................................**DATE**...............................................

**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. |

**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 |  |