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

PATIENT ETHNICITY QUESTIONNAIRE

This short questionnaire will give surgery 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/joining the practice.

Name.. **DOB**......................

Do you need an interpreter or sign language support? **Yes/No**

If you do need an interpreter what language do you speak? 9NU%

Please state……………………………………………………….

What is your ethnic group?
Choose **ONE** section from A to E then tick **ONE** which **best describes** your ethnic group or background.

A White

Scottish 9S13
English 9i20
Welsh 9i22
Northern Irish 9i24
British 9S10
Irish 9S11
Gypsy/Traveller 9i2E
Polish 9i2F
Any other white ethnic group, please write in 9S12

B Mixed or multiple ethnic groups

Any mixed or multiple ethnic groups 9SB

C Asian, Asian Scottish or Asian British

Pakistani, Pakistani Scottish or Pakistani British 9S7
Indian, Indian Scottish or Indian British 9S6
Bangladeshi, Bangladeshi Scottish or Bangladeshi British 9S8
Chinese, Chinese Scottish or Chinese British 9S9
Other, please write in 9SH

D African, Caribbean or Black

African, African Scottish or African British 9S3
Caribbean, Caribbean Scottish or Caribbean British 9S2
Black, Black Scottish or Black British 9S41
Other, please write in... 9S4

E Other ethnic group

Other, please write in... 9SJ

F Other.

Ethnic group – patient refused 9SD

MOBILE TEXT MESSAGE CONSENT

We are using a mobile phone text message service. We will be using this service to send out appointment reminders and may also contact you to arrange appointments when necessary.

Are you willing to give consent for this service?

YES **NO**

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2.2	Oct 2013	Updated Sep 2015

Dornoch Medical Practice

NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

Introduction

This questionnaire can be used to capture data for new patient registrations. It will also help to establish a base-line view of the patient's lifestyle and will assist the nurse/doctor in carrying out a new patient health check. The information provided will also assist in the identification of "at risk" patients and focus care advice on at-risk areas.

>>> Continues on next page >>>

NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

To the Patient:

To register with the practice, please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment. Patients will be asked to attend the practice for an initial consultation and some basic checks.

Surname: .... Forename(s): ....

Date of Birth: .... Marital status: ....

Address: ....

.... Postcode: ....

Home tel: .... Mobile: ....

Email address: ....

Is it ok for the surgery to contact you by e-mail Yes/No

Occupation: ....

Weight (approx) in Kg's: .... Height in cm's: ....

Date of completion of this form: ....

Smoking

Do you smoke? *Yes / No*

If *Yes*, how many...: Cigarettes per day .... Ounces of tobacco per day ....

If yes, please collect a leaflet from reception. Leaflet given *Yes/No*

How old were you when you started smoking? ....

Ex-Smokers

How old were you when you stopped smoking? ....

How much did you smoke per day? ....

Passive Smoking

Are you exposed to passive smoke at work? *Yes / No* At home? *Yes / No*

Alcohol

For the following questions please circle the answer that best applies:
One drink = 1/2 pint of beer/one glass of wine/one single measure of spirits

Do you drink alcohol regularly? *Yes/No*
If yes, how many units of Alcohol do you consume in a week? ....

Men: How often do you have EIGHT or more drinks on one occasion?
Women: How often do you have SIX or more drinks on one occasion?
Never Less than monthly Monthly Weekly Daily/Almost Daily

How often during the last year have you failed to do what was normally expected of you because of drinking?
Never Less than monthly Monthly Weekly Daily/Almost Daily

How often during the last year have you been unable to remember what happened the night before because you had been drinking?
Never Less than monthly Monthly Weekly Daily/Almost Daily

In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?
Yes No

Diet

Do you have a varied diet including milk, meat, vegetables and fruit? *Yes / No*

Has your cholesterol been checked in the last two years? *Yes / No*

Exercise

Do you take regular exercise? *Yes / No*

If yes, what sort of exercise? ....

How many minutes do you typically spend exercising per session? ....

How many times do you exercise per week? ....

Family History

Is there any of the following in your family *(father, mother, brother, sister)* before the age of 65?

Heart Disease (e.g. heart attacks, angina) *Yes / No* which family member? ....

Stroke? *Yes / No* which family member? ....

Cancer? *Yes / No* which family member? ....

Diabetes? Yes/No which family member? ....

Asthma? Yes/No which family member?............................

Site of cancer? ....

Medication

Please give details of any medication which you take (prescribed or otherwise):

Name of drug: .... Name of drug: ....

Dosage: .... Dosage: ....

Name of drug: .... Name of drug: ....

Dosage: .... Dosage: ....

Name of drug: .... Name of drug: ....

Dosage: .... Dosage: ....

Name of drug: .... Name of drug: ....

Dosage: .... Dosage: ....

Allergies

Are you allergic to any medication? Yes/No

If Yes, please give details:

....

....

I

Are you allergic to any substances or foods e.g. gluten, pollen, Latex? *Yes / No*

If *Yes*, please give details:

....

....

Past Medical History

Please give details of any hospital treatment as an in-patient:

....

Please give details of any treatment for any chronic medical conditions:

....

Please give dates of any X-ray/MRI or CT scans/mammogram/ultrasound.:

....

Immunisations if known

....

....

....

Female Patients

Date of most recent cervical smear: ....

Result of most recent smear ....

Current contraception used if any ....

Do you have any children? Yes/No Number of children: ....

Please give details of any complications in pregnancy:

....

....

....

Carers

Do you need / have anyone who looks after you or your daily needs as Carer? *Yes / No*

If *Yes*, would you like them to deal with your health affairs here? *Yes / No*

The receptionist can help with these arrangements

Do you care for anyone else? *Yes / No*

If *Yes*, please ask the receptionist about Carers support

General

Do you feel you need to see a Doctor or a Nurse in the next 4 weeks Yes/No

Are there any other issues which cause you concern or would you like advice on any other health problems? Please give details below:

Thank you for completing this questionnaire. Your doctor will assess the information provided and will invite you for an initial examination, discussion about your health, and general check within the next few days.