APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE

ALL FIELDS MARKED * ARE MANDATORY AND MUST BE COMPLETED AS FULLY AS POSSIBLE

NHS SCOTLAND

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

NEW PATIENT REGISTRATION FOR CHILD UP TO 6 YEARS

Name:	Date of Birth:
Address: Postcode: Telephone: Home - Work - Mobile - Male/Female:	Ethnicity (please see attached form to help): Do you require an interpreter, if YES in which language? Occupation Height Weight
Last Doctors Name: Surgery: Address:	Next of Kin Address Telephone

Have you been registered with this surgery previously Yes/No

CHILDHOOD IMMUNISATIONS

	YES	NO
Do you think that your child's vaccinations are up to date		

If NO, which ones do you think maybe missing?

MEDICAL PROBLEMS -Please list any medical problems or operations that your child has had

Date	Medical problem/Operation

IS YOUR CHILD TAKING ANY MEDICATION? IF YES PLEASE LIST BELOW – If you have a repeat prescription slip from your previous medical practice please attach it to this form

Name of drug	How many times each day is the drug taken?	Dose of drug

ALLERGIES

	YES	NO
Does your child have any allergies?		
If YES please list below		

Signature of patent/guardian	Date

Thank you for completing this form. Please hand it back to the reception desk

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Administration section only: 1) *Receptionist to tick here* if telephone consultation (TC) made for rpt prescriptions or face to face consultation (F/F) made - _____(T/C)_____(F/F)
2) *Data processor to tick and sign the form and date here* - _____ (SPICE)_____ (ETHNICITY) _____ (CARER) _____ (Signature) _____ (date)

ETHNICITY FORM – READ Coding template

If you have already completed this form, please **do not** complete it again.

NAME: _____

DATE OF BIRTH: _____

What is your **ethnic group**? (Choose **ONE** section from A to F then tick **ONE** box which best describes your ethnic group)

		READ codes
A.	**WHITE**	
❑	Scottish	**9S13**
❑	Other British	**9S10**
❑	Irish	**9S11**
❑	Gypsy / Traveller	**9T2**
❑	Polish	**9i2F**
❑	Other white ethnic group	**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 Asian, Asian Scottish or Asian British	**9SH**
D.	**AFRICAN**	
❑	African, African Scottish or African British	**9S3**
❑	Other African	**9SA5**
E.	**CARIBBEAN OR BLACK**	
❑	Caribbean, Caribbean Scottish or Caribbean British	**9S2**
❑	Black, Black Scottish or Black British	**9S41**
❑	Other Caribbean or Black	**9SG**
F.	**OTHER ETHNIC GROUP**	
❑	Arab, Arab Scottish or Arab British	**9iF9**
❑	Other ethnic group	**9SJ**

❑ IF YOU WOULD PREFER NOT TO ANSWER PLEASE TICK HERE **9SD**

❑ IF YOU DO NOT KNOW YOUR ETHNICITY PLEASE TICK HERE **9SE**

DURHAM ROAD MEDICAL GROUP

HV REGISTRATION INFORMATION

Family Name ……

Mum's Name ……

Dad's Name …… DOB_____

Child's Name …… DOB_____

Child's Name …… DOB_____

Child's Name …… DOB_____

Child's Name …… DOB_____

Child's Name …… DOB_____

Child's Name …… DOB_____

Address …….
…….
…….
…….

Prev Address ……
…….
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…….

GP Address ……
…….
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…….

TEXT MESSAGING AT DURHAM ROAD MEDICAL GROUP

Here at Durham Road Medical Group we are introducing a new text messaging system. This is where you can receive a text message reminding you of upcoming appointments, inviting you in for healthcare reviews (COPD, asthma, diabetes etc.) It can also let you cancel appointments or accept these invitations without having to come in or contact us.

If you are happy and would like to receive text messages from Durham Road then please tick the **'ACCEPT'** box, fill out your personal details and sign at the bottom of the page.

If you would not like to receive text messages from Durham Road then please tick the **'DECLINE'** box, fill out your personal details and sign at the bottom of the page.

Please note; we will only send information that is relevant to the individual and will not send spam. We will also not send any sensitive information such as test results via text message.

I have read and understood how my data will be used by Durham Road Medical Group and **ACCEPT AND CONSENT** to receiving text messages from the practice. ☐

I have read and understood how my data will be used by Durham Road Medical Group and **DECLINE AND DO NOT CONSENT** to receiving text messages from the practice. ☐

Name _____

Date of Birth_____

Mobile Number_____

Signature_____ Date_____

If you are signing on behalf of a child please fill in the following details.

Childs Name _____

Parent/Guardians Name _____

Contact Number _____

Signature _____ Date _____