APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE

NHS SCOTLAND

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 complete a temporary resident form)

Date of Birth* DD - - YYYY

Title*

Surname*

Forenames*

Previous Surname*

email address #

Address*

Postcode*

Telephone #

Mobile #

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 Community Health Index (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 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* DD - - YYYY

If previously resident in the UK, date of leaving* DD - - YYYY

Your most recent country of residence

If you have served in the British Armed Forces:

Service Number

Enlistment date* DD - - YYYY

Are you a Reservist?* ☐ Yes ☐ No

Leaving date* DD - - YYYY

Is this your first registration with a GP since leaving the Armed Forces?* ☐ Yes ☐ No

If yes, please provide your address before enlisting*

Postcode*

3. VOLUNTARY AUTHORISATION FOR ORGAN OR TISSUE DONATION

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick the boxes that apply. Your consent to organ donation will be shared with NHS Blood and Transplant together with the information you have provided in Section 1 including your name, gender, date of birth address and CHI number. For more information on being an organ donor or privacy, please ask for the leaflet on joining the NHS Organ Donor Register or visit www.organdonationscotland.org

Any of my organs and tissue ☐ Or my

Kidneys ☐ Eyes ☐ Heart ☐ Lungs ☐ Liver ☐ Pancreas ☐ Small bowel ☐ Tissue ☐

Notes on tissue - heart valves and corneas come under the 'heart' and 'eyes' boxes respectively so the 'tissue' box covers donating other types of tissue, such as your tendons.

Patient signature _____ Date DD - - YYYY

4. HOW WE USE YOUR 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 DD - - YYYY

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 photocopies

*Please initial each relevant box (it is recommended that at least one form of 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 - 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 DD - - YYYY

7. OFFICIAL USE ONLY

Input by

Checked by

Date DD - - YYYY

Practice Stamp

New Patient Questionnaire

Bathgate Primary Care Centre

Welcome. Please help us by filling in this questionnaire as it may take some time for your previous medical records to reach us. The information you give will be used to provide you with good medical care.

Have you been a patient at the practice before ? Yes / No

Title:	Full name:
Date of Birth:	Address and Postcode:
Maiden Name:	
Next of Kin:	
Next of Kin address Tel No: Relationship[:	Contact details: Landline: Mobile: Email: Please tick if relevant:: Military Veteran .....Ex Military.....
Country of Origin: Do you need an interpreter? If yes, what language?	Occupation .....

MEDICATION AND TREATMENT

Can you please bring a printed list or labels from your medication bottles along with you to your first appointment with a health care professional.

Do you have any allergies?,.....

PAST HEALTH Please give details of any pregnancies, important illnesses or operations

Date:_____ Illness (details Please) _____

Date:_____ Illness (details Please) _____

Date:_____ Illness (details Please) _____

Date:_____ Illness (details Please) _____

LIFESTYLE

Do You smoke? Yes / No If No have you ever smoked Yes / No

How many units* of alcohol do you drink per week? _____
If none, are you completely teetotal Yes / No *1 unit = 1 glass wine, 1 glass spirit or half pint of beer

Do you keep to a diet? _____ If yes, please give details _____

Do you undertake regular sport or exercise? _____

If yes, please give details and frequency _____

Height..... Weight.....

FAMILY HISTORY

Have any of your father/mother/sisters/brothers suffered from:

ASTHMA:_____Age_____ HIGH CHOLESTEROL _____Age_____

DIABETES:_____Age_____ HEART TROUBLE _____Age_____

CANCER:_____Age_____ STROKE_____Age_____

THYROID DISEASE:_____ EPILEPSY _____Age_____

HIGH BLOOD PRESSURE :_____ Age_____

FEMALE PATIENTS ONLY

When was your last cervical smear taken _____Where_____

Result_____

CARERS

Carers are people who look after a partner, husband or wife, son & daughter, relative or friend with a disability. Carer live with the person they care for, but many look after someone who lives independently. Carers are family members or friends who look after someone without financial reward.

ARE YOU A CARER : YES/NO

IF YES WHO DO YOU CARE FOR:

NAME:_____D.O.B. _____

ADDRESS:_____

Is the patient registered with this practice?

If yes, can we pass your information to Carer's of West Lothian? YES/NO

ETHNIC BACKGROUND

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

A White Scottish ☐ Other British ☐ Irish ☐

Any other White background (please specify)_____

B Mixed Any Mixed background (please specify)_____

C Asian, Asian Scottish or Asian British

Indian ☐ Pakistani ☐ Chinese ☐ Bangladeshi ☐

D Black, Black Scottish or Black British Caribbean ☐ African ☐

E Other Ethnic background (Please specify) _____

Simpson Medical Group

Text Message Information (over 16yrs only)

Patient Name.....D.O.B.....

Home Tel No.....Mobile.....

I understand the practice might wish to contact me via text message for future things such as

- Appointment Reminders
- Chronic Disease.Recalls
- Seasonal Flu Info
- General Info

I understand that if I change my phone number it is my responsibility to inform the practice of this.

I have no objection to being contacted this way.

Signature..... Date.....

If completing on behalf of a patient

Print your Name.....

Relationship to Patient.....

Signature.....Date.....