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

Maybole Medical Practice

Dr L Adams
Dr C Martin
Dr M Barr
Dr G Vernon

Appointments: 01655 882708
Prescriptions: 01655 883922
Fax: 01655 882977
Ref: 80491

Maybole Health Centre
6 High Street
MAYBOLE
KA19 7BY

www.maybolemedicalpractice.co.uk

New Patient Questionnaire - Adult

Please complete this form to aid us with your care whilst we await your full medical records.

By providing these contact details you give consent for the practice to contact you in this way

Title		First name	
Surname			
Date of birth			
Telephone numbers	Home		
	Mobile		
	Work		
	Other		
Email address			

Do you require a translator/interpreter? If so, which language		Do you require a hearing loop?	Yes No
Does someone look after you? If so, who?		Do you look after someone? If so, who?	
Do you have a Power of Attorney/Welfare Guardian? If so, who?			
Ethnic origin			
Height (cms)		Weight (kg)	

Do you have any of the following medical conditions?			
Heart Disease		Diabetes	
Stroke		Epilepsy	
High Blood Pressure		Cancer	
Thyroid Disorders		Asthma	
Chronic Kidney Disease		Chronic Obstructive Pulmonary Disease (COPD)	
Any other illnesses or operations			

	Drug Name	Dose/Strength	Frequency
Please list your current medications			

Please list any allergies	

What is your current smoking status? (please circle)	Current Smoker Ex-Smoker Never Smoked	Would you like help to stop smoking?	Yes No
Do you drink alcohol?	Yes No	How much alcohol do you consume per week? (*One unit of alcohol = half a pint of beer, one glass of wine or sherry or one measure of spirits*)	

	Please advise the date and result of last screening
Cervical Screening (Aged 25-64)	
Breast Screening (Aged 50-70)	
Bowel Screening (Aged 50-74)	
Do you use any contraception or HRT? Please state the type of contraceptive you use	

Have you had any of the following vaccinations in the last 10 years?	Date Given
Tetanus	
Influenza	
Pneumococcal	
MMR (Measles/Mumps/Rubella)	
Hepatitis B	
Hepatitis A	
Shingles	

Any other information which you think we should know?

Office Use Only
New Patient Check Appointment Offered Declined