

APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE **NHS**
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 *

Address *

Title *

Surname *

Forenames *

Previous surname *

Postcode *

Email address #

Telephone #

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 *

Name and address of previous GP Practice in 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:

Service Number

Enlistment date *

Are you a Reservist?

If you 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.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 NHS Scotland 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

Representative's name (if applicable)

Relationship to patient (if applicable)

Date *

6. FOR PRACTICE USE

GP reference number

Practice code

GP name

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

NAME DOB

Q. What is your ethnic origin

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

Bangladeshi

Chinese

Any other Asian Background. Please specify _____

D. Black, Black Scottish or Black British

Caribbean

African

Any other Black background Please specify _____
Please write in

E. Other Ethnic background

Please specify _____

Portland and Meadowgreen Surgeries Adult Questionnaire

Computer
Scanned

Surname: Title: Mr/Mrs/Miss/Ms/Dr/Rev Please circle one

Forenames: Date of Birth:

Ethnic Origin

Telephone Numbers: Home: email:
Work:
Other:

Next of kin: Relationship to you:

Address: Tel No:

Do you have a Carer YES/NO. If yes name of Carer..... Contact number

Are you Carer YES/NO. If yes name of person you care for Contact number

Have you had any ongoing health issues, serious illnesses or operations? If so, could you please list them:

.....
.....
.....

Are you allergic to anything? If so, please list them?

.....
.....

Are you taking any medications?

Drug Name	Dose/strength	Frequency

Which Pharmacy would you like your repeat prescriptions to go to?

Have any of your immediate family suffered from a heart attack or angina? Yes/No

Have any of your immediate family suffered from a stroke? Yes/No

Are you a smoker? Yes/No If yes, how many a day?:

Ex-Smoker? Yes/No

How much alcohol due you consume per week? :

..... 1 unit of alcohol is equivalent to half a pint of beer, one glass of wine, sherry or one measure of spirits

When did you last have a tetanus vaccination?

When did you last have a polio vaccination?

Approximate date:

Approximate date:

Women only

Have you had a hysterectomy?

Yes/No

When did you last have a smear test?

Approximate date:

Was this smear normal?

Yes/No

Do you have a coil in place?

Yes/No

Do you have a contraceptive implant?

Yes/No

Type: Date Fitted:

Is there any other information that you think we should know?

Please be aware that you are registering with the GP Partnership. We have 2 Practice buildings in Troon (Meadowgreen Surgery and Portland Surgery) and at times patients will be offered appointments at either Practice site depending on what is available. Please note that some services are not available at both sites. We will always try and appoint you at the Practice of your choosing but sometimes this may not be possible

FOR PATIENTS BORN BEFORE 1996

UK INFECTED BLOOD ENQUIRY – HEPATITIS C TESTING

Patient Label

**1 DO YOU THINK YOU MAY HAVE HAD A BLOOD TRANSFUSION
PRIOR TO 1996?**

YES NO

**(CIRCLE ABOVE AS REQUIRED – IF YES THE PRACTICE WILL BE IN
TOUCH WITH ADVICE)**

(STAFF – PLEASE HAND COMPLETED FORM TO PM FOR ACTION)