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 #

Mobile #

Email address #

 # 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

Portland Park Medical Centre

YOUR PERSONAL INFORMATION

Name: …… Date of Birth: ……..

Address: ……

Postcode: …… Tel. No. ……..

Marital Status: …… Occupation: ……

Ethnic Origin: ……..

If you need an interpreter, which language do you speak? ……..

Next of Kin Contact Details: ……

……

Relationship to Next of Kin: ……..

GENERAL HISTORY:

Are there any illnesses you suffer from…….

…….

Please list any medication that you are currently taking:

……..

……..

Please list any allergies you have:

……..

Please tick one of the following:
[ ] Non-smoker [ ] Ex-smoker – when did you stop? ……
[ ] Smoker – how many daily ? ……

How much alcohol do you consume per week? (1 unit = half pint beer, 1 glass wine, 1 measure spirit)
……

How much exercise do you take in an average week? (Exercise that makes your heart race!!)
[ ] Nil [ ] Little [ ] Moderate

CARERS:

Are you a carer? [ ] Yes [ ] No

If yes who do you care for? ……

Do you have any contact with the Social Work Department? [ ] Yes [ ] No

FEMALE PATIENTS ONLY:

Date & Result of Last Smear ……..

Do you self examine your breasts? [ ] Yes [ ] No

TELL US ABOUT YOUR FAMILY HISTORY:

Which of you blood relatives have suffered from any of the following:

[ ] Heart disease …… [ ] Cancer ……..

[ ] Diabetes …….. [ ] High blood pressure ……

[ ] Asthma …… [ ] High cholesterol ……

[ ] Stroke …….. [ ] Epilepsy …….

KEEPING US UP TO DATE

Please make sure that you keep your contact details, including contact telephone numbers up to date. It is vital that we have the means to always contact you. The surgery cannot be held responsible for the misdirection of information if your contact information is out of date. You can nominate a family member as your contact – please inform our admin team of this should you wish to do so.

I have completed this form and understand the information given to me about the appointment system.

Signed: …… Date: ……..

Online Services - Patient registration form

If you would like to register for online services with Portland Park Medical Centre, please complete the form below and return it, along with a valid form of identification, for example photo ID. Once you are registered, the practice will give you the information that will enable you to create a user name and password. Please allow up to 3 working days to be registered.
By signing this document, you have read and agreed to the terms and conditions for this service.

Patient details	
Patient forename	
Patient surname	
Date of birth	
Email address	
Shared email addresses	If you are sharing your email address with other people, Portland Park Medical Centre cannot protect any information you provide against access from the other users of your email address, nor can Portland Park Medical Centre prevent other users of your email address from viewing or receiving emails from the Practice intended for you. Portland Park Medical Centre will deactivate online access for any child sharing an email address with a parent or another person when they reach the age of 16yrs. They should then re-register for online services using an email address of their own. **Once you are registered, you will receive a token ID code, which you should use to set up your online account. You will receive this via the email address you provided.**
Mobile number	
Signature	
Date	
If completed by someone other than the patient	
Print forename	
Print surname	
Relationship to patient	
Signature	
Date	

For practice use only	
Patient ID seen	
Type of ID seen	
Staff name	
Date	