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* ☐☐ - ☐☐ - ☐☐☐☐

Address*

Title*

Surname*

Forenames*

Postcode* ☐☐☐☐ ☐☐☐

Previous Surname*

Telephone #

email address #

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*

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* ☐☐ - ☐☐ - ☐☐☐☐

If yes, please provide your address before enlisting*

Are you a Reservist?* ☐ Yes ☐ No

Leaving date* ☐☐ - ☐☐ - ☐☐☐☐

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

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 ☐☐ - ☐☐ - ☐☐☐☐

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 ☐☐-☐☐-☐☐☐☐

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 ☐☐-☐☐-☐☐☐☐

7. OFFICIAL USE ONLY

Input by _____

Checked by _____

Date ☐☐-☐☐-☐☐☐☐

Please complete both sides

CONFIDENTIALITY POLICY

We maintain our legal duty of confidentiality to you at all times. We keep this information in a secure, confidential manner. All staff working within the Practice are bound by the same high standards of confidentiality. We will only ever use or pass on information about you if others involved in your care have a genuine need for it. We will not disclose your information to third parties without your permission unless there are exceptional circumstances, such as where health and safety of others is at risk or where the law requires information to be passed on. Any information that may identify you is only shared with the practice team, or, if you are referred to hospital, to the clinician who will be treating you. We will only share information about you with anyone out with the above if you give your permission in writing.
All our staff is trained to ensure that any information we hold about you remains confidential. This is in accordance with the GDPR May 2018 and acknowledges the Gender Recognition Act 2004

■ DATE ■TITLE

■ SURNAME ■ FORENAME(S)

■ DATE OF BIRTH

■ ADDRESS ■ FLAT NUMBER

■ POST CODE

■ TELEPHONE NUMBER home: work: mobile:

TEXT MESSAGES : Do you give consent to receive text messages YES NO

■ GENDER (delete as appropriate)
Male (including trans men) Female (including trans women) Non-Binary/In another way (please state)

If you have a preferred pronoun, tell us (e.g. him her they) .....
Is your gender identity the same as you were assigned at birth? (delete as appropriate)
Yes No

■ SEXUAL ORIENTATION (delete as appropriate)
Heterosexual or Straight/Lesbian or Gay/Bisexual/In another way (please state)

■ EXPECTED DURATION OF STAY IN UK

■ STATUS single/married/widow(ed)/divorced/separated/cohabiting/child

■ OCCUPATION Are you currently employed YES/NO

■ NHS NUMBER

■ NEXT OF KIN name relationship

address

telephone

■ PLEASE LIST OTHER MEMBERS OF YOUR FAMILY WHO ARE REGISTERED AT THIS PRACTICE

Name	Date of Birth	Relationship
	■	■
	■	■
	■	■
	■	■

■ **PRESENT MEDICATION including medication that is not prescribed**
(medication not prescribed may include over the counter preparations e.g. aspirin, herbal/homeopathic remedies).

NAME OF DRUG	STRENGTH	HOW OFTEN TAKEN
1.	■	■
2.	■	■
3.	■	■
4.	■	■
5.	■	■
6.	■	■
7.	■	■

■ **PREVIOUS IMPORTANT ILLNESSES/OPERATIONS from birth in order**

ILLNESS	■DATE	■ TREATMENT and, if relevant, hospital
	■	■
	■	■
	■	■
	■	■

FAMILY DISEASES

Parent/brother/sister – heart disease first occurring under age 60	yes/no
Parent/brother sister – stroke first occurring under age 60	yes/no
Parent/brother/sister – diabetes	yes/no
Parent/brother/sister – breast cancer, colorectal cancer under age 45	yes/no
Other diseases – no/yes details	

■ **ALLERGIES** **Please circle YES / NO**

Details .....

■ **SMOKING**

Never smoked	
Ex-smoker/year stopped	
Vapes	
Cigarette smoker	/per day
Roll-ups	/ozs per day
Pipe-smoker	
Cigar-smoker	
Cannabis or other Recreational drugs	

■ **ALCOHOL** per week

Stopped drinking alcohol
Teetotaller
Trivial drinker- < 1u/day
Light drinker – 1-2u/day
Moderate drinker – 3-6u/day
Heavy drinker – 7-9u/day
Very heavy drinker - .9u/day

■ **Do you need an interpreter?** **Please circle YES / NO**

If so, which language? .....

HEALTH INFORMATION

Height: ..... **Weight:** .....

Smoking status: Never smoked Current smoker Ex-smoker

Alcohol status [How many units do you drink per week?]: .....

Do you have any known allergies? .....

Regular Medication [Please list any drugs you are prescribed or buy from the chemist – please include the contraceptive pill. Please include the strength of the drug and how often you take it.]

Continuing Health Problems [Please include long term conditions such as asthma, diabetes, angina/heart disease, high blood pressure or any other condition which may require monitoring by members of the health team.]

Major Illnesses, Operations or Accidents [Please include dates if possible.]

Is there a history of diabetes in your family? Yes No

Is there a history of heart disease in your family? Yes No

Children under 16 [Please tell us the names of your children and their ages.]

For women only – cervical smear history

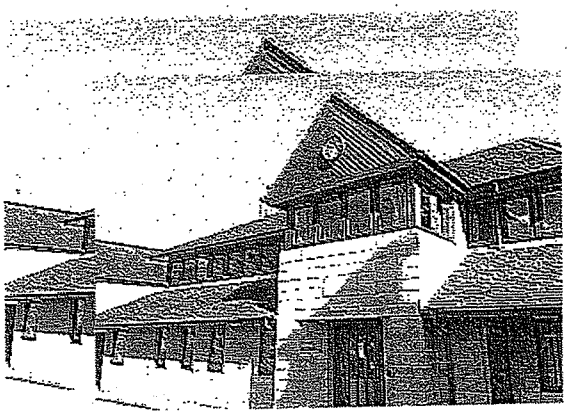
Date of last smear: ..... **Result: Normal/Abnormal**

Please give details of any abnormal smears with treatment received:

.....

Thank you for taking the time to fill out this questionnaire.

Mill Lane Surgery
4 Mill Lane, Edinburgh EH6 6TL
Tel 0131 554 1274 Website www.milllanesurgery.co.uk



NEW PATIENTS

Please note **we do not automatically** continue prescriptions of -

: **Methadone**

: **Tramadol**

: **Benzodiazepines**

: **Gabapentin**

: **Pregabalin**

: **Dihydrocodeine and other OPIATES**

Requests for the above medication will be at the **discretion of our Doctors.**