APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE

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 *

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

KINGS PARK SURGERY
274 Kings Park Avenue, Glasgow, G44 4JE

NEW PATIENT ETHNICITY FORM

Patient Name: .....

Date of Birth: .....

Do you require an Interpreter if yes which language .....

Ethnic Group: PLEASE TICK ONE OF THE FOLLOWING CATEGORIES

A. White
- ○ Scottish (9i21)
- ○ British (9S10)
- ○ Irish (9S11)
- ○ Any other White background (specify) (9i2)

B. Mixed
- ○ White and Asian (9i5)
- ○ White and Black African (9i4)
- ○ White and Black Caribbean (9i3)
- ○ Any other mixed background (specify) (9i6)

C. Asian or Asian British
- ○ Bangladeshi (9i9)
- ○ Indian (9i7)
- ○ Pakistani (9i8)
- ○ Any other Asian or Asian British background (specify) (9iA)

D. Black or Black British
- ○ African (9S3)
- ○ Caribbean (9S2)
- ○ Any other Black or Black British background (specify) (9S4)

E. Other ethnic Background
- ○ Chinese (9iE)
- ○ Any other background (specify) (9iF)

F. Prefer not to say
- ○ Not Stated (9SE)

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NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE
PLEASE COMPLETE ALL SECTIONS

FULL NAME: .....

ADDRESS: .....

.....

DATE OF BIRTH: / /

SINGLE / MARRIED / SEPARATED / WIDOWED / CO-HABITING / CIVIL PARTNERSHIP

(please circle as appropriate)

OCCUPATION: .....

TEL NUMBER: ..... **MOB TEL NUMBER:** .....

TEXT MESSAGE REMINDER SERVICE
I **do not wish / wish** (*delete as appropriate*) to consent to the Text message reminder service offered by Kings Park Surgery.

Patient Signature_____ **Date** _____

(Reception please code #9NdP for consent or #9NdQ for consent declined)

NEXT OF KIN: ..... **RELATIONSHIP:** .....

NEXT OF KIN CONTACT TELEPHONE NUMBER: .....

PAST MEDICAL HISTORY AND CURRENT HEALTH
ILLNESS OR OPERATIONS (please list)

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ARE YOU CURRENTLY SEEKING ASYLUM: YES/NO

(Reception please code #13ZN.00)

IF YOU WERE BORN BEFORE 1996 HAVE YOU HAD A BLOOD TRANSFUSION IN THE UK? YES/NO

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REPEAT MEDICATIONS (please list Drug Name, Strength, Frequency)

DRUG NAME	STRENGTH	FREQUENCY

DO YOU HAVE ANY ALLERGIES? YES / NO (please circle as appropriate)

IF YES, PLEASE STATE .....

PLEASE TICK WHICHEVER STATEMENT APPLIES RE SMOKING STATUS. IF A SMOKER/EX-SMOKER, PLEASE ANSWER QUESTIONS

SMOKING STATUS:

NEVER SMOKED			
SMOKER		How many per day?	
EX-SMOKER		When did you stop?	

FAMILY HISTORY

	Age(s)	Health (or cause of death)
Father		
Mother		
Brothers and Sisters		
Children		

Please circle as appropriate

DIET NORMAL LOW FAT HIGH FIBRE VEGETARINAN

EXERCISE NONE OCCASIONAL REGULAR

ALCOHOL INTAKE

KINGS PARK SURGERY

274 Kings Park Avenue, Glasgow, G44 4JE

HOW MANY UNITS OF ALCOHOL DO YOU DRINK PER WEEK?
(One unit = glass of wine/half pint of beer/a measure of spirit)

FEMALES ONLY

DATE OF LAST SMEAR / /
NUMBER OF PREGNANCIES

IMMUNISATION STATUS

CHILDHOOD VACCINES
LAST TETANUS
FOREIGN TRAVEL VACCINES

Are you responsible for anyone's care at home, other than your children? Y/N

Are you responsible for caring for anyone in their own home or elsewhere? Y/N

Any other information you might feel relevant?

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FOR PRACTICE USE ONLY

PAST MEDICAL HISTORY

MEDICATIONS

EXAMINATION

BP		**HEIGHT**	

URINE		**WEIGHT**	

SMOKING CESSATION ADVICE GIVEN (#8CAL)

Patient is: CARER (#918A) OR HAS A CARER(#918F)