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. 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

NEWFIELD MEDICAL
GROUP LTD.
EST.2022

Newfield Medical Group
Registration Questionnaire – under 16 years

Forename	Surname	D.O.B
Mother's name If you have any issues providing this information please contact the practice on 01382 432030 to discuss further		**Mother's DOB**

Do you have any ongoing health problems? Do you attend any hospital clinics?
What illnesses, injuries or operations have you had in the past?
Nominated pharmacy Tell us know your preferred pharmacy (even if you don't receive regular medication)
What medicines do you take at present? Please provide a print out of your current prescribed medication.

Do you require repeat medication in the next 2 weeks? If yes you may need to request this from your current practice.	Yes	No

Please Note: you may require an appointment with a doctor before a new prescription is issued from us.

Do you have any allergies? Including drug allergies?
Are there any problems or illnesses that your family has or had? Such as Asthma, Coronary Heart Disease or Type 1 or 2 Diabetes etc FATHER - MOTHER - BROTHER(S) / SISTER(S) OTHER

All Patients

Do you care for someone in your family or a close friend?	Yes	No
Does someone care for you?	Yes	No
Would you like to be referred to Social Services for a carer's assessment?	Yes	No
Would like to be referred to the Dundee Carers centre?	Yes	No

This form will give staff some basic information about your communication needs and ethnicity to better support your health care. Please ask a member of staff if you need more explanation.

Do you need an interpreter or sign language support? ☐Yes ☐No

Please state which language .....

What is your ethnic group?
Choose ONE section from A to E then tick ONE box which best describes your ethnic group or background
If you do not wish to give this information, please tick here ☐

A White

- ☐ Scottish
- ☐ English
- ☐ Welsh
- ☐ Northern Irish
- ☐ Irish
- ☐ Polish
- ☐ Other please Specify .....

B Asian, Asian Scottish or Asian British

- ☐ Pakistani, Pakistani Scottish or Pakistani British
- ☐ Indian, Indian Scottish or Indian British
- ☐ Bangladeshi, Bangladeshi Scottish or Bangladeshi British
- ☐ Chinese, Chinese Scottish or Chinese British
- ☐ Other Please Specify .....

C African, Caribbean or Black

- ☐ African, African Scottish or African British
- ☐ Caribbean, Caribbean Scottish or Caribbean British
- ☐ Black, Black Scottish or Black British
- ☐ Other, please write in .....

D Multiple Ethnic Group

- ☐ Please Specify .....

E Other ethnic group

- ☐ Please specify .....

HOW WILL WE USE YOUR DATA

Your contact details may be passed to other services for the provision of healthcare, for example if you are referred to the hospital or other services including physiotherapy, district nurses etc.

Online prescription order
Self help:
- Your health
- Your child
- Mental health
- Lifestyle advice

Scan Me