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 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

Portobello/Conan Doyle - Health Questionnaire - please fill this in

As a new patient to the Practice we would like to offer you a health check with one of our Practice Nurses if you are taking any medications or have a long term condition such as asthma, diabetes or COPD.

Our health visitor would also like to meet with parents of children under the age of 5.

Name:	
Address/Postcode:	
Date of Birth:	
Are any members of your household registered with this practice? If so, please give details (full name and date of birth)	
Next of Kin (please give name, address and contact details)	Name: Address: Tel: Relationship:
Power of Attorney Held by:	

As part of your medical care may we share information with the Out of Hours, the local hospitals and other emergency health services? Please write YES or NO to consent/dissent to us sharing your information: .....(**Consent can be withdrawn at any time by contacting the Surgery.)**

Signature: .....

We may wish to contact you via text messaging and/or email about your health. We need your consent to contact you in this way. It is also important the information we hold is kept up-to-date. Please keep us informed of any changes to your contact details. **Please write YES or NO below to indicate consent/withdrawal to contact**. (**Consent can be withdrawn at any time by contacting the Surgery.)**

Landline:		**Consent to contact on landline number**	yes
Mobile:		**Consent to contact by SMS text**	yes
Email:		**Consent to contact by email**	yes
Signature:			

What is your height?		**What is your weight?**	

www.nhs.uk/livewell has advice on healthy living for everyone

How much exercise do you usually do in a week?

I am a current smoker □ **I am an ex-smoker** □ **I have never smoked** □	**If you are a smoker and want to quit please call the local stop smoking support service on 0131 672 9532 or call SMOKEFREE on 0800 022 4332 or Visit http://smokefree.nhs.uk. Trained NHS advisors can provide friendly help & encouragement. https://committochange.stickk.com**

Do you drink alcohol? - If yes, how many units per week?

◯ **Yes** _____/week (1 unit is a glass of wine, half pint of beer or 1 measure of spirits)

◯ **No**

Are you a Carer? YES ◯ NO ◯ If so – who are you a carer for …….

Have you got a Carer? YES ◯ NO ◯ If yes – who is your carer ……..…….....

(Carers are family members or friends who are looking after or supporting someone who is frail, ill or disabled and being a carer brings challenges. For information to support carers:Vocal www.vocal.org Tel 0131 622 6666 Edinburgh Carer Support Team www.edinburgh.gov.uk/ Tel 0131 536 3371

Date and result of Last Cervical Smear _____

Have you had your BP checked in the last 5 years? ◯ YES / ◯ NO

It is recommended that all adults should have a routine BP check every 5 years.

Those of us over 50 are advised to have bowel screening every 2 yrs. New kits from Tel 0800 0121 833

Has anyone in your family ever suffered from heart disease (heart attacks/angina), or diabetes?

Please give brief details with approx age when condition ocurred.

Do you take any medication regularly that should be on a repeat prescription? Please list medication with name, strength and when you take them.

Please indicate which Pharmacy you would like us to send your prescriptions to: Please choose below

FOR OFFICE USE ONLY Has patient been informed of new patient health check? ☐ YES / ☐ NO

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity to support your health care.

Do you have any communication issues you need assistance with? Eg Hearing Vision Reading or Writing

Do you need an interpreter or sign language support? ◯ YES / ◯ NO

If you do need an interpreter what language do you speak? *Please state* ……

What is your ethnic group?

Eg White Scottish, Asian Scottish, Black British, White Irish *Please state*.....

We are asked to collect this information to help plan health service provision

If you do not wish to give this information, please tick here ☐
If you do not know your ethnicity please tick here ☐

Do you have any housing concerns? ◯ YES / ◯ NO

Ask the administration team if you would like any help contacting someone.

Council Housing Officer: Tel 0131 529 5050
Cyrenians Homeless Prevention Service Tel 0131 475 2556 e-mail hps@cyrenians.org.uk
Edinburgh Housing Advice Partnership Tel 0131 442 1009 or 0845 302 4607

They can help if you are threatened with eviction and offer advice for a range of housing issues www.ehap.org.uk

Dr Comiskey and Partners
265 Portobello High Street
Edinburgh EH15 2AW
Tel: 0131 669 8406

Revised January 2017 (K Lee) - Revised April 2018 (Dori)
Revised Oct 2020 (YMcBeth) Update 2024