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

Blackfriars Medical Practice
St Andrews Community Hospital
Largo Road, St Andrews,
Fife, KY16 8AR

Tel 01334 477477
www.blackfriarsmedicalpractice.gp.scot

ADULT MEDICAL QUESTIONNAIRE AND CONTACT PREFERENCES

1. Contact information

Title _____ Name _____ Date of birth _____

Address _____ Tel home _____

Mob _____ Email address _____

2. Who is your next of kin?

Name: _____ Relationship to you: _____

Telephone: _____ Mobile no.: _____

3. Do you have any allergies to any substances/medications? Yes ☐ No ☐ If Yes, please state below:

Allergy _____ Reaction _____
Allergy _____ Reaction _____
Allergy _____ Reaction _____

4. Have any of your relatives had any of the following conditions? If so please detail who:

Name _____ Heart Disease _____
Epilepsy _____ Diabetes _____
Stroke _____ Hypertension _____

5. Have you any current medical problems requiring ongoing treatment? Yes ☐ No ☐

a) _____ b) _____
c) _____ d) _____
e) _____ f) _____

6. Alcohol intake

Do you drink alcohol? Yes ☐ No ☐ If yes, how many units per week? _____

7. Smoking

Do you smoke? Yes ☐ No ☐ If yes, how many a day? _____
Are you an ex-smoker? Yes ☐ No ☐ If yes, when did you stop? _____

8. Height and Weight

What is your current height? _____ CM
What is your current weight? _____ KG

CONTACT INFORMATION AND CONSENT TO TEXT MESSAGING AND EMAILS

Please complete this form and return it to the Practice.

Name..... DOB.....

Home telephone number..... Mobile number.....

Email address.....

The Practice can contact me by text (please tick) YES ☐ NO ☐

The Practice can contact me by email (please tick) YES ☐ NO ☐

The telephone numbers and email address I have provided are those of a parent (please tick)
YES ☐ NO ☐

The telephone numbers and/or email address is shared with another person (please specify below)

I confirm I understand what is being asked of me and that if my parent's details are held on my record as contact information, they will receive text reminders of my appointments and may be contacted by the Practice regarding other matters.

If a mobile number or email address is shared with another person, I understand that person will have access to information sent by the Practice by text or email, for example appointment reminders.

Signed.....

The Practice will update your records in line with your wishes. You can contact us at any time if you wish to make any changes. If you are under **16** years of age we will check with you again in a year.