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

WELCOME TO THE PRACTICE

Dr M Johnston, Dr P Murray, Dr T Randall, Dr C Johnston, Dr N Harper, Dr L Fraser, Dr J Flinn, Dr C Gordon, Dr A Eadie

Practice Manager: Mrs Lisa Herd

Patient Health Form

Have you previously registered with this practice?	**YES / NO**

Surname	
First name(s)	
Date of Birth	
Mobile / contact tel no.	
Email address	
Occupation	
Are you registered Disabled?	YES / NO
Number of Children/Dependants Age(s)	

Is there any "**family history**" of the following (family meaning parents, brothers, sisters). Those marked * only answer if you are under the age of 60
*Stroke □ *Angina/Heart Attack □ Diabetes □ Asthma □ High Blood Pressure □

Ethnicity: White Scottish □ White British □ Indian □ Chinese □ European □ Other Asian □.....	
What is your first Language?	
Do you need an interpreter?	

Do you have a carer? (if yes, please give details)	
Are you a carer? (if yes, please give details)	

Are you a veteran?	

Have you suffered any of the following?

Epilepsy	YES / NO	Blindness / Glaucoma	YES / NO
High Blood Pressure	YES / NO	Diabetes	YES / NO
Heart Attack / Stroke	YES / NO	Asthma	YES / NO
Cancer	YES / NO	COPD	YES / NO
Depression	YES / NO	Hay Fever	YES / NO
Other Mental Health problem	YES / NO		

Please give details of any operations, serious illnesses or hospital admissions

..... Date: .....

..... Date: .....

..... Date: .....

Your Height: ..... Your Weight: .....

Do you smoke?	YES / NO
If yes, how many per day?	
Have you ever smoked?	YES / NO
Would you like advice to stop?	YES / NO

Do you drink Alcohol?	
How many units of Alcohol per week do you drink?	

Do you take regular exercise? :

.....

WOMEN ONLY:

Have you had a smear test YES / NO Date of last test..... Result:.....
Do you have a coil (IUCD) fitted YES / NO If yes, please give date? ..... Date of last check .....
Do you have a contraceptive implant YES / NO If yes, please give date?.....

CURRENT MEDICATIONS

WE LIKE YOU TO HAVE A PRINTED LIST (DATED WITHIN THE LAST 2 WEEKS) FROM YOUR LAST DOCTOR, PLEASE HAND THIS TO THE RECEPTIONIST WITH THIS FORM.

WE MAY NEED TO CONTACT YOUR PREVIOUS GP BEFORE WE CAN PRESCRIBE FOR YOU. THIS IS FOR YOUR OWN SAFETY.

Name of medication	**Dose**

ALLERGIES

Please give details of any allergies (foods, medications etc)

.....

.....

.....

Next of Kin

Name	
Address **Postcode**	
Contact Number	
Relationship to you	
Do you hold a living will?	**YES / NO**
A **living will** is a written, legal document that spells out medical treatments you would and would not want to be used to keep you alive, as well as your preferences for other medical decisions, such as pain management or organ donation.	

Patient Access: (ordering medication and booking appointments online).

- **I would like to sign up for EMIS Patient Access YES / NO**
- **Please send me the registration details by email. YES / NO**

I would like to sign up for text reminder services when they become available.

I confirm that all the above details are correct.

I accept that it is my responsibility to keep the surgery informed of all changes to any of my contact details.

Signed:	
Date	

THANK YOU.
PLEASE PICK UP A COPY OF OUR PRACTICE BOOKLET OR VISIT
WWW.COWDENBEATHMEDICALPRACTICE.CO.UK
THIS PROVIDES YOU WITH USEFUL INFORMATION ABOUT THE PRACTICE
IF YOU HAVE A MEDICAL CARD PLEASE HAND IT TO RECEPTION WITH THIS FORM

COWDENBEATH MEDICAL PRACTICE

173 Stenhouse Street
Cowdenbeath
Fife
KY4 9DH
Tel. No. 01383 518500
Fax No. 01383 518509

Practice Manager: Mrs Lisa Herd

Dr. Marion Johnston
Dr. Anne Eadie
Dr. Paul Murray
Dr. Lucy Jones
Dr. Colin Johnston
Dr. Tom Randall
Dr Jenny Flinn
Dr Carla Gordon

CONSENT

NAME :
.....

Permanent Address: .....

.....

Temporary Address: .....
(If applies)

.....

Date of Birth: ..... Tel No.:.....

PLEASE COMPLETE SECTION **1 OR 2** WHICH EVER SECTION APPLIES
SIGN SECTION 3

SECTION 1

I*consent / *DO NOT consent to the release of *FULL or *PART of my medical records by Cowdenbeath Medical Practice to:

.....

If Part medical records, please specify dates from .....to.....

SECTION 2

*I consent to my Registered GP/GP Practice releasing medical information to Cowdenbeath Medical Practice for the purposes of health care provision during my temporary registration with Cowdenbeath Medical Practice

Key Information Summary/Emergency Care Summary :
*I consent to Cowdenbeath Medical Practice accessing my emergency care summary, hospital electronic records for the purpose of health care provision etc.

Registered GP Name/Practice: .....,

Tel: .....

I understand that all written communications regarding my health care will still be sent to me at my address registered with Cowdenbeath Medical Practice

SECTION 3

Signed Consent:.....

Print Name: ..... Date: .....

*Delete as appropriate/if applicable