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

BALLATER CLINIC

NEW PATIENT QUESTIONNAIRE

Please complete this **confidentia**l form Date:

Name:	Date of Birth:
Address:	
Post Code:	
Home Tel No.	Mob No.
Email address:	
Tick box if you **DO NOT** wish to be contacted by SMS or E-mail ☐	
Occupation:	

Next of kin info

Name:	Tel No.
Address:	
Relationship of Relative/Friend:	
Are you a Carer - Do you look after a relative or friend? Yes☐ No☐ If yes, please give details	
Do you have a Carer? Yes☐ No☐ If yes, please give details	

MEDICAL HISTORY

Do you suffer from any of the following?:

Diabetes ☐ Epilepsy ☐ Asthma ☐ Stroke ☐ Angina ☐ High Blood Pressure ☐

Heart Disease ☐ COPD ☐ Atrial Fibrillation ☐ Cancer ☐

Peripheral Vascular Disease ☐ Mental Health Problems/Depression ☐

Have you ever had any major operations/serious illness? Yes ☐ No ☐
If yes please detail below:

Operation/Illness	Date
Immunisations:	
Date of last Tetanus Immunisation:	

MEDICATION

Please list any regular medication, including the dosage and how often taken

Name of Drug	Strength	How often taken

If you are on repeat medication you can ask to register for our online service.

Are you allergic to any medication Yes ☐ No ☐

Name of Drug	Reaction experienced

Do you suffer from any other allergy i.e. peanuts, eggs, etc? Yes ☐ No ☐

Allergy	Reaction experienced

LIFESTYLE
Smoking Habits:

Current Smoker		How many cigars/cigarettes do you smoke per day?		Date Started
Ex Smoker		How many cigars/cigarettes did you smoke per day?		Date Stopped
Never smoked				

Alcohol consumption:
Please estimate your alcohol intake per week (1 unit = half pint of beer or 1 glass of wine (125ml or small glass) or 1 pub measure of spirit)

Number of units per week	

FAMILY HISTORY

	Age and state of health	Age at death and cause
Mother		
Father		
Brothers		
Sisters		
Any **hereditary disease** in your family? eg Glaucoma, Cystic Fibrosis Please provide details		

Ladies Only
Have you had a cervical smear Yes ☐ No ☐

Do you have a Coil, Implanon or Nexplanon fitted? Yes ☐ No ☐

Date fitted/last check up:…….....

All New Patients - Please bring a sample of urine to your patient registration appointment with the Practice Nurse

Vision Online - Patient registration form

If you would like to register for this online service please complete the form below and return it to your practice in person, **along with a valid form of identification, for example photo ID or your passport.**

Once you are registered the practice will give you the information that will enable you to create a username and password.

Patient details	**Please complete in BLOCK CAPITALS**
Patient forename	
Patient surname	
Date of birth	/ /
Email address **This email address will be used by your practice to send you notifications and reminders.**	
Mobile number	
Consent to SMS	
Signature	
Date	/ /
Completing the form on behalf of the patient?	
Print forename	
Print surname	
Relationship to patient	
Signature	
Date	/ /

Staff use only	
Patient ID seen	
Type of ID	
Staff name	
Date	/ /

About Vision online services

We offer an online service for our patients so you can book your appointments and order your repeat prescriptions online at your convenience.

Online appointment booking

Have the flexibility to book and cancel your appointments from home, at work or any location with internet access. You don't need to queue at the practice, wait on the telephone and you can manage your appointments outside practice opening hours.

Request your repeat prescriptions online

Request your repeat prescriptions quickly online by logging into your account and simply ticking the appropriate boxes. You can review the progress of your repeat prescriptions and any message that the practice may have sent to you.

If you are interested in finding out more about the Vision clinical system we use at our GP practice please visit **www.inps.co.uk**.

inps
A CEGEDIM COMPANY

Vision SMS Text Messaging Service – Consent Form

To register for this Vision SMS Text Messaging Service, please complete the consent form below and return it to your practice in person.

Patient details	**Please complete in BLOCK CAPITALS**
Patient forename	
Patient surname	
Patient address	
Date of birth	/ /
Landline number	
Mobile number	

This mobile number will be used by your practice to send you appointment reminders and also will be used for health care invitations, such as flu clinic reminders.

PLEASE SIGN BELOW TO GIVE YOUR CONSENT FOR THE ABOVE INFORMATION TO BE USED BY THE PRACTICE

Signature	
Date	/ /
Completing the form on behalf of the patient?	
Print forename	
Print surname	
Relationship to patient	
Signature	
Date	/ /

About SMS text messaging

An alternative method of communicating with patients is being introduced. This will be a secure text messaging service enabling the practice, with patient consent, to send health care invitations and appointment reminders to patients by SMS text messages.

PLEASE NOTE IT IS THE PATIENTS RESPONSIBILITY TO PROVIDE THE PRACTICE WITH UP TO DATE CONTACT DETAILS INCLUDING ADDRESS AND TELEPHONE NUMBERS.