

APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE



1. PERSONAL DETAILS (ALL FIELDS MARKED * ARE MANDATORY AND MUST BE COMPLETED AS FULLY AS POSSIBLE)

Male* Female* 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)

Date of Birth*	<input type="text" value="DD"/> - <input type="text" value="MM"/> - <input type="text" value="YYYY"/>	Address*	<input type="text"/>
Title*	<input type="text"/>		
Surname*	<input type="text"/>		
Forenames*	<input type="text"/>	Postcode*	<input type="text"/> <input type="text"/>
Previous Surname*	<input type="text"/>	Telephone #	<input type="text"/>
email address #	<input type="text"/>	Mobile #	<input type="text"/>

The following information can be found on your current medical card:

Community Health Index (CHI) Number*	<input type="text"/>	NHS Number*	<input type="text"/>
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The following information can be found on your birth certificate:

Town of Birth*	<input type="text"/>	Country of Birth*	<input type="text"/>
Registered district of birth (Scotland only)	<input type="text"/>	Mother's maiden name	<input type="text"/>

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

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*	Name and address of previous GP Practice in UK*
<input type="text"/>	<input type="text"/>
Postcode* <input type="text"/> <input type="text"/>	Postcode* <input type="text"/> <input type="text"/>

If you are from abroad:

Date you first came to live in the UK*	<input type="text" value="DD"/> - <input type="text" value="MM"/> - <input type="text" value="YYYY"/>	If previously resident in the UK, date of leaving*	<input type="text" value="DD"/> - <input type="text" value="MM"/> - <input type="text" value="YYYY"/>
Your most recent country of residence	<input type="text"/>		

If you have served in the British Armed Forces:

Enlistment date*	<input type="text" value="DD"/> - <input type="text" value="MM"/> - <input type="text" value="YYYY"/>	Service Number	<input type="text"/>
Are you a Reservist?*	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide your address before enlisting*	<input type="text"/>
Leaving date*	<input type="text" value="DD"/> - <input type="text" value="MM"/> - <input type="text" value="YYYY"/>		
Is this your first registration with a GP since leaving the Armed Forces?*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Postcode*	<input type="text"/> <input type="text"/>

3. VOLUNTARY AUTHORISATION FOR ORGAN OR TISSUE DONATION

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick the boxes that apply. Your consent to organ donation will be shared with NHS Blood and Transplant together with the information you have provided in Section 1 including your name, gender, date of birth address and CHI number. For more information on being an organ donor or privacy, please ask for the leaflet on joining the NHS Organ Donor Register or visit www.organdonationscotland.org

Any of my organs and tissue Or my

Kidneys Eyes Heart Lungs Liver Pancreas Small bowel Tissue

Notes on tissue - heart valves and corneas come under the 'heart' and 'eyes' boxes respectively so the 'tissue' box covers donating other types of tissue, such as your tendons.

Patient signature _____ Date - -

4. HOW WE USE YOUR INFORMATION

The information you have provided will be used by the GP Practice 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 cards, 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 make sure that the information which identifies you as a person and your health information are separated or anonymised. Health condition and treatment information which could identify you will not be used for research purposes by the NHS unless you have consented to this.

For more information on how NHS National Services Scotland uses your personal information visit www.nhsnss.org. If you have any queries or concerns about how your personal information is used by the NHS please ask for the leaflet 'Confidentiality – it's your right', visit the NHS Inform website at www.nhsinform.co.uk/rights/ or ask your GP surgery.

NHS National Services Scotland is the common name of the Common Services Agency for the Scottish Health Service.

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, relevant information from this form will be disclosed to the NHS Business Services Authority, NHS National Services Scotland, the Home Office, Identity and Passport Service, HM Revenue and Customs, the General Register Office and Local Authorities.

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 - Mileage (No.) Road Water Footpath

Identification seen - do not take or retain photocopies

Please initial each relevant box (it is recommended that at least one form of identification is seen to positively identify the applicant)

Birth Cert. Student ID Card Driving Licence Passport or HC2 Cert. Home Office App Reg Card Other/None - specify Receptionist initials

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. OFFICIAL USE ONLY

Input by

Checked by

Date - -

Practice Stamp