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 three months? Yes No

***(If no please complete a temporary resident form)***

Male Female

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

Date of Birth

Title

Surname

Forenames

Previous Surname

Email

Telephone

Mobile

Home Address

*The data supplied in these fields will not be input to, or updated in the Community Health Index but will be held in the GP Practice System*

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

Community Index Number (CHI)

NHS Number

Town of Birth

Country of Birth

Registered Distict of Birth

County of Birth

Mother’s Maden Name

1. **Previous GP information**

Address where you last

Registered with a GP

Name and address of

Previous GP Practice in

UK

If you are from abroad:

|  |
| --- |
|  |
|  |

Date you first came to UK

If previously resident in UK date of leaving

Your most recent country of residence

If you have served in the British Armed Forces: Yes No

Enlistment Date

Service Number

Leaving Date

If a reservist, address before enlisting

Is this your first registration since leaving? Yes No

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 shares 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 organdonationscotland.org.

All My organs and Tissue

Eyes Kidneys Heart Lungs Liver

Pancreas Small Bowel Tissue

**How we use Information**

Information you have provided will be used by NHS Scotland to carry out its various functions and services including scheduling appointments, hospital referrals and sending correspondence.

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, make payments to GP Practices for medical services provided and to process and issue medical exemption certificates and entitlement cards.

National services Scotland shares information about you within NHS Scotland to assist in the provision and improvement of NHS Services and health of the public. When we do this, we do it as described by NHS Scotland in the NHS Inform Website.

NHS Scotland is made up of various organisations such as NHS Health Boards, GP Practices, the Scottish Ambulance Service or NHS National Policies Scotland. These organisations are individually responsible for your personal health information. In terms of data protection and privacy laws they are known as ‘Data Controllers’

**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 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.

|  |
| --- |
|  |
|  |
|  |
|  |

Patient/Representatives Signature

Date

Representatives Name (If Applicable)

Relationship to Patient

|  |
| --- |
|  |
|  |
|  |

**Practice Use**

Reference Number

Practice Code

GP Name

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 will be subject to Payment Verification.

|  |
| --- |
|  |
|  |

Authorised Practice Signature

Date

**NEW PATIENT QUESTIONAIRE**

Welcome to Tiree Medical Practice. To make sure we have up to date important details about your health, we request that you complete the following questionnaire and then attend a new patient screening appointment with Cairin MacLeod, our practice nurse.

|  |
| --- |
|  |
|  |
|  |
|  |
|  |

Name

Date of Birth

Home Telephone

Mobile Number

Address

|  |
| --- |
|  |
|  |

Emergency Contact

Power of Attorney (Name and Contact)

Consent to share key information with national database for our of hours emergency use? Yes No

Medications

Previous Medical Problems

Allergies and Intolerances

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

Did you receive standard childhood immunisations?

Have you had any boosters for tetanus since?

Have you had any immunisations in connection with your work?

Or any in connection with age/medical condition?

Do you have regular cervical smears?

Do you have mammograms?

Do you use contraception or a coil?

Please detail how many children and miscarriages you have had and any details of any pregnancy related problems.

Any other information