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## South Queensferry Medical Practice

**for all new patients aged 12 years and over**

Please complete all forms and attend in person with these signed forms together with **two forms of ID:**

* 1. one with a photo ie passport or driving licence **AND**
  2. one proving your address in our practice area - utility bill, rental agreement, bank statement, mortgage agreement etc

Children under 12 years

* Birth certificate or passport

Newborn

* The white NHS form for new babies supplied by registrar when registering the birth.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***Office Use Only – TWO FORMS OF ID CHECKED:*** | | ***Initials:*** |  | ***Date:*** |  |
| ***Details:*** | ***1.*** | ***2.*** | | | |
| ***GDPR fully completed and signed -* Y 🞎** | | | | | |

**PERSONAL DETAILS**

|  |  |  |  |
| --- | --- | --- | --- |
| **SURNAME** |  | | |
| **FIRSTNAME(s)** |  | | |
| **Date of Birth** |  | | |
| **Mobile/Contact no** |  | **Occupation** |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Have you ever been registered with this practice either temporarily or permanently before?** | | | | | | | |
| **Y 🞎 N 🞎** | | | | | | | |
| **Are you a military veteran? Y 🞎 N 🞎** | | | | | | | |
|  |  | | |  | |  |
| **Next of Kin name:** |  | | | **Relationship:** | |  |
| **Contact number for Next of Kin:** | |  | | | | |
|  | |  | | | | |
| **Other Members of Household** | | Name: | | | DOB: | |
| Name: | | DOB: | Name: | | | DOB: |

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| --- | --- | --- | --- |
| **Past Medical History** inc operations, referrals to hospital specialists, psychiatric illness | | | **Date** |
|  | | |  |
|  | | |  |
|  | | |  |
| **All Current Medication** *(Attach the reorder form of previous prescription if you have one)*and list all other current medications below: | | | |
|  |  |  | |
|  |  |  | |
|  |  |  | |
| **Medicine Allergies:** *(eg penicillin)* | | | |
|  |  |  | |
|  |  |  | |
|  |  |  | |
| **Allergies:** *(eg hayfever)* | | | |
|  |  |  | |
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| --- |
| Have you had any contact with Drug Agencies? Y 🞎 N 🞎 |
| Have you had any contact with Social Care? Y 🞎 N 🞎 |

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| **SMOKING** | | | |
| Do you currently smoke? | Y 🞎 N 🞎 | How many per day? |  |
| Have you ever smoked in the past? | Y 🞎 N 🞎 | | |
| If a past smoker, how many per day? |  | When did you stop smoking? | |

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| **ALCOHOL –** The Chief Medical Officers' guideline for **both men and women** is that: To keep health risks from alcohol to a low level it is safest **not to drink more than 14 units a week** on a regular basis.  C:\Users\isobel.speirs\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Word\a661b920f06e57f2713a646c805c5f5a419c61df[1].jpg**14 units = 6 pints 4% beer or 6 glasses of 175ml 13% wine.** | | |
| What is your alcohol intake: | Daily: units | Weekly: units |

|  |  |  |
| --- | --- | --- |
| **Do you look after a relative, partner or friend who needs support because of age, physical or learning disability or illness, including mental ill health?** | | Y 🞎 N 🞎 |
| If Yes, who do you care for? Name: | | |
| Address: | | |
| **Parent(s) of children aged 0-16 years:** | | |
| Has your child ever been on the Child Protection (At Risk Register) at any time? | Y 🞎 N 🞎 | |
| Does your child/family have any social work involvement? | Y 🞎 N 🞎 | |
| Does your child have a learning disability? | Y 🞎 N 🞎 | |

Please select ethnicity:

Black African 🞎 Black Other 🞎 Chinese 🞎 Filipino 🞎 Indian 🞎 Irish Traveller 🞎

Mixed ethnic group 🞎 Roma 🞎 White 🞎

Any other ethnic group 🞎 (please write in) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_

Decline to answer 🞎

|  |  |
| --- | --- |
| ***Office use only:*** *Date form processed:*  *Staff name:* |  |

|  |
| --- |
| **Thank you for completing this questionnaire.** |
| **Signed: Date:** |

**APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE**

**ALL FIELDS MARKED \* ARE MANDATORY AND MUST BE COMPLETED AS FULLY AS POSSIBLE**

# PERSONAL DETAILS

Is this your first registration with a Yes 🞏 No 🞏 Will you be in the area for more Yes 🞏 No 🞏

GP Practice in the UK? than 3 months?

*(If ‘No’, please complete a temporary resident form)*

Male \* 🞏 Female \* 🞏

Date of birth \* Address \*

Title \*

Surname \*

Forenames \*

Previous surname \* 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 | Mother’s maiden name\* |

*(Scotland only)*

# 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 \***

Postcode \* 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 🞏 If yes provide your address before enlisting \*

Leaving date \*

Postcode \*

Is this your first registration with a GP since leaving the armed forces? Yes 🞏 No 🞏

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# 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

# 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 com](https://www.nhsinform.scot/care-support-and-rights/health-rights/confidentiality-and-data-protection/how-the-nhs-handles-your-personal-health-information)mon 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.

# 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)

# FOR PRACTICE USE

GP reference number GP name

Practice code

**78171**

## 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 🞏 Home Office 🞏 Other / None

HC2 cert app reg card

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 \*

# FOR OFFICIAL USE ONLY

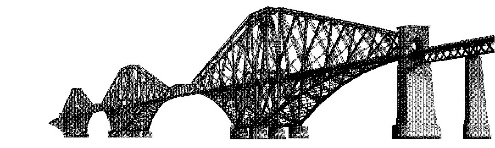
|  |
| --- |
| Practice stamp |

Input by

Checked by

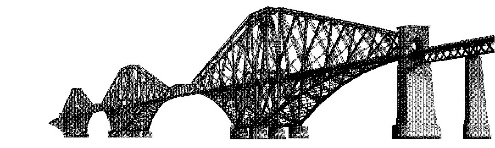
Date

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**South Queensferry Medical Practice**

|  |  |  |  |
| --- | --- | --- | --- |
| **FULL NAME** |  | | |
| **DOB** |  | | |
| **Please tick if have been diagnosed with any of the following conditions:** | | | |
| **Condition** | |  | **Date of Diagnosis**  **(year will be helpful if full date unknown)** |
| Angina/Heart Attack | | Y 🞎 N 🞎 |  |
| Asthma | | Y 🞎 N 🞎 |  |
| Bariatric Surgery | | Y 🞎 N 🞎 |  |
| Blood Pressure (high) | | Y 🞎 N 🞎 |  |
| COPD | | Y 🞎 N 🞎 |  |
| Diabetes | | Y 🞎 N 🞎 |  |
| Heart Failure | | Y 🞎 N 🞎 |  |
| Kidney Disease | | Y 🞎 N 🞎 |  |
| Prostatectomy | | Y 🞎 N 🞎 |  |
| Stroke | | Y 🞎 N 🞎 |  |
| Thyroid Disease | | Y 🞎 N 🞎 |  |



**South Queensferry Medical Practice**

**Patient Services Registration Form**

**Enjoy the convenience of ordering your prescriptions and booking GP face-to-face appointments at any time of the day or night, wherever you are. Using the Patient Services website on your computer or mobile, you can order prescriptions and book GP face-to-face appointments.**

**Patients aged 16 and over must have their own individual email address to apply for a Patient Services account. The provisions are in place in order to comply with GDPR regulations.**

For parents applying for a Patient Services account for a child aged 12-15, if the child is deemed to have capacity (they are competently able to make their own decisions) then they will be required to have an individual email address. **Accounts for younger children and those not deemed to have capacity, can use a parent/carer email.**

To register for this online service please complete this form and hand into reception. On receipt of this completed form, we will email the address given to confirm we have the correct email address. On receipt of a reply, we will generate the account set-up letter to enable you to set up your Patient Services Online Account.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Title |  | Firstname | |  | Surname |  | |
| Date of Birth |  | | | | Age if under 16? | |  |
| Phone number |  | | | | | | |
| **Email address - please write clearly in capital letters** | | |  | | | | |
|  | | | | | | | |
| **Preferred Prescription Pick-up – please select ONE from the list below:**  Ferryburn Pharmacy, South Queensferry *(collect daily from surgery)*  Queensferry Pharmacy, South Queensferry *(collect daily from surgery)*  Well Pharmacy, Kirkliston *(collect twice a week Tuesday and Thursday)*  Omni Pharmacy, Queensferry Road *(collect twice a week Tuesday and Friday)*  Barnton Pharmacy, Whitehouse Road *(collect twice a week Tuesday and Friday)*  Boots Pharmacy, The Gyle *(collect twice a week Wednesday and Friday)* | | | | | | | |
| **Thank you for completing this form for Patient Services - please sign and date below.** | | | | | | | |
| **Signed: Date:** | | | | | | | |

***FOR OFFICE USE ONLY*: ID PRESENTED AT TIME OF REGISTRATION:**