APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE

NHS SCOTLAND

1. PERSONAL DETAILS (all fields are mandatory and must be completed as fully as possible)

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

PERSONAL DETAILS	Please complete in BLOCK CAPITALS		
Surname			
First Names			
Middle Names			
Previous Surname			
Date of Birth			
Community Health Index (CHI)			
Sex *(please circle)*	MALE/FEMALE	**Title** *(please circle)*	Mr/Mrs/Ms/Miss or Other .....
Address (Please insert Flat/Room No:/Letter if applicable)	F L A T		R O O M
Postcode			
Mobile No			
Landline No			
Email Address			
Town of Birth		**Country of Birth**	
Registered District of Birth *(Scotland Only)*		**Mother's Maiden Name**	

2. HELP US TRACE YOUR PREVIOUS GP HEALTH RECORDS (by providing the following information)

Address in UK when you were last registered with a GP *(including address if you were a Reservist)*	
Name and address of previous GP in the UK	

If you are from abroad:

Date you first came to live in the UK	

If previously resident in the											
Your most recent country of residence											

If you have served in the British Armed Forces: Service Number _____

Enlistment Date											
Leaving Date											

Are you a Reservist? *(If YES, please provide your address above)*	YES/NO	**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 YOUR 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 the 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 NHS Scotland 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 information" section.

NHS Scotland is made up of various organisations such as NHS Health Boards, GP practices, the Scottish Ambulance Service or NHS 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 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 Code [ ] - [ ] GP Name _____

Practice Code [T1136] - [3]

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 OFFICE USE ONLY

Input by _____ **Date** _____

HAWKHILL MEDICAL CENTRE – NEW PATIENT QUESTIONNAIRE

Welcome to Hawkhill Medical Centre. Please complete the details below as part of the registration process. The information provided is confidential and will form part of your medical records.

Patient Details	**Please complete in BLOCK CAPITALS**
Patient First Name	
Patient Surname	
Date of Birth	
Name of Next of Kin: (Emergency Contact)	
Next of Kin Address:	
Next of Kin Mobile No:	
Next of Kin Landline No:	

Are you a Carer? (Please Circle)	YES/NO	**Do you have a Carer? (If YES, please complete below)**	YES/NO
Name of Carer:			
Carer's Mobile No:			
Carer's Landline No:			

PATIENT INFORMATION

Weight (kg/lbs):		**Height (cm/inches):**	
Smoker:	YES/NO	**Amount/Day:**	
Ex Smoker:	YES/NO	**Approx Date Stopped:**	
Alcohol Consumption:	YES/NO	**Approx units/week:**	

Date of last smear: *(female only)*		**Result:**	
Hysterectomy: *(female only)*	YES/NO	**Date of Operation:**	

MEDICAL HISTORY

Please list any major operations/illnesses:	**Please list any current medication including contraception:**

P.T.O.

Please list any DRUG or FOOD allergies:	**Please list any immunisations that you have had:**

	PERSONAL HISTORY (Please Circle)	**FAMILY HISTORY (Mother/Father/Sibling) (Please Circle)**	
Heart Disease	YES/NO	YES/NO	
Stroke	YES/NO	YES/NO	
High Blood Pressure	YES/NO	YES/NO	Date BP last checked:
Asthma	YES/NO	YES/NO	
COPD	YES/NO	YES/NO	
Diabetes Type 1 or Type 2	YES/NO	YES/NO	
Epilepsy	YES/NO	YES/NO	Date of last seizure:
Kidney Problems (NOT infections)	YES/NO		

ETHNICITY INFORMATION?

Please choose **ONE** section and then tick **ONE** box which best describes your ethnic group or background.

White

- [ ] Scottish
- [ ] English
- [ ] Welsh
- [ ] Northern Irish
- [ ] British
- [ ] Irish
- [ ] Gypsy/Traveller
- [ ] Polish
- [ ] Other, please specify ……

Mixed or multiple ethnic groups

- [ ] Any mixed or multiple ethnic groups

Asian

- [ ] Pakistani, Scottish or British
- [ ] Indian, Scottish or British
- [ ] Bangladeshi, Scottish or British
- [ ] Chinese, Scottish or British
- [ ] Other, please specify ……

African, Caribbean or Black

- [ ] African, Scottish or British
- [ ] Caribbean, Scottish or British
- [ ] Black, Scottish or British
- [ ] Other, please specify ……

Other Ethnic Group

- [ ] Arab
- [ ] Other, please specify ……

Do you require an interpreter or sign language support? YES/NO **If yes, which language?** ……

Signed: …… Date: ……..

Dr. Andrew Cowie
Dr. Kelly Frullani
Dr. Emma Fardon
Dr. Muhammad Zafar
Dr. Louise Bowie
Dr. Tim Esler

HAWKHILL MEDICAL CENTRE

215 HAWKHILL
DUNDEE
DD1 5LA
Telephone:
01382 669589

Email, Text Messaging & Online Patient Services

We are delighted to introduce an Email, Text Messaging & Online Service for our patients. This service will allow you to access the following:

Email & Text Messaging Service

- Receive appointment confirmations & reminders by text message
- Cancel appointments by text message
- Receive invitations to clinics by text message or email
- Receive messages & questionnaires from the practice by text message or email

Online Patient Services

- Order your Repeat Prescriptions online
- Book advance GP appointments online
- Cancel appointments booked online

Please complete the registration form overleaf to sign up for these services. Please ensure you tick each box confirming your consent for us to use this method to contact you.

Once registered we will provide information that will enable you to create your Online Patient Services username and password.

Please note if you wish to register other family members for any of these services a separate registration form is required for each person.

You can opt out of these services at anytime by contacting the Practice in person or by telephone on the above number.

Hawkhill Medical Centre processes personal identifiable information that relates to patients and is therefore required by law to comply with the General Data Protection Regulations (GDPR), which protect your privacy and ensure that your personal information is processed fairly and lawfully. If you require any further information, please ask at reception for a copy of our Privacy Notice or access via our website at www.hawkhillmedicalcentre.co.uk.

P.T.O.

Email, Text Messaging & Online Patient Services – Registration Form

If you would like to register for any of these services please complete the form below and return it to reception with a valid form of identification.

You can opt out of these services at anytime by contacting the Practice in person or by telephone.

Patient details	**Please complete in BLOCK CAPITALS**
Patient First Name	
Patient Surname	
Date of Birth	- -
Email Address ***This email address may be used by the practice to send you appointment confirmations/reminders/ clinic invites/messages.*** ***Please tick if you consent to using this service.***	**I consent to receiving text messages/emails: YES NO**
Mobile Number	-
	Please ensure that you notify us if you change your mobile number o email address:
Please tick which service you wish to sign up for *(you can sign up to both)*	**Online Patient Services Text Messaging & Email Service**
Signature	
Date	- -
Completing the form on behalf of the patient?	
Your First Name	
Your Surname	
Relationship to Patient	
Your Signature	
Date	- -

Staff use only		**Input to Vision**	*Please tick* (√)
Check all details above have been completed		Mobile No	
		Email Address	
	Please tick (√)	Consent Read Code	
Type of ID Seen		Online Patient letter	

Staff Initials		Staff Initials	
Date		Date	