

# NEWBATTLE MEDICAL PRACTICE

## REGISTRATION ADVICE SHEET - ADULT

To allow us to process your registration efficiently with Newbattle Medical Practice and NHS Lothian, **please complete ALL sections of the attached forms and return to us with the following items of identification:**

1. Proof of identification = ONE of the following:
  - Valid passport
  - Valid photo driving licence (Not Provisional)
  - NHS Medical Card – Call 0131 275 7076
  - Birth Certificate

### **AND**

2. Proof of address = ONE of the following:
  - A Utility Bill **dated within one calendar month of date of registration.**
  - A Council Tax bill/Rent Letter **dated within one calendar month of date of registration.**
  - A Bank Statement **dated within max 3 calendar months of date of registration.**

If you don't have any of the above, please speak to a receptionist who will be happy to advise what we may accept instead.

**\*\* The Registration process takes up to 2 weeks to complete. Should you require medication or fitness notes within this period please see your existing practice \*\***



**Newbattle Medical Practice  
New Patient Questionnaire**

**www.newbattlemedicalpractice.co.uk**

Please let the receptionist or nurse know if you have any difficulty completing this form.

**Date form completed:** .....

**Part 1 Personal information**

Name:	Date of birth:
Address (including postcode):	Home telephone number:
Email address:	Work telephone number:
	Mobile telephone number:
Current occupation:	Marital status :
Previous Address:	Name and address of previous GP:
If you are changing from (or have been unable to register with) another GP practice in this health centre, please state your reason for changing? We may ask to discuss this with you.	

It is very useful for us to be able to link family records. Please list below the names and dates of birth of any children for whom you have parental responsibility. Please indicate if the child lives at the same address as noted above.

Child's forename	Child's surname	Date of birth	Child's relationship to you	Same address?

Do you care for somebody with a disability?	Yes / No
Do you have a carer?	Yes / No

## Part 2 Medical information

Prescribed medication: please list any medications that you take regularly (or attach the repeat prescription list from your previous GP)

Drug name	Strength	Dose instructions	Illness prescribed for
<i>eg loratadine</i>	<i>10mg</i>	<i>1 tab in the morning</i>	<i>hayfever</i>
.....	.....	.....	.....
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Allergies (please state drug name and type of reaction eg rash, nausea, severe collapse):

### Alcohol Intake:

Do you drink alcohol? Yes / No

If yes, how much in number of units per week:

Wine: ..... Spirits: ..... Beer: .....

1 unit = 1 small glass wine **or** 1 single measure spirits **or** half pint (standard strength) beer

### Smoking:

Please circle one of the following: never smoked / ex-smoker / current smoker

If you smoke, are you interested in help to stop smoking? Yes / No

You can get advice on services to help you stop smoking from reception.

**Past medical History:**

Do you suffer from any of the following?

Please tick any relevant conditions and add more information below if necessary.

- Asthma
- Atrial fibrillation (irregular heart beat)
- Cancer
- Coronary heart disease (angina, heart attack)
- Chronic obstructive pulmonary disease (COPD, emphysema, chronic bronchitis)
- Dementia
- Depression (currently being treated)
- Diabetes
- Epilepsy
- Heart failure
- Hepatitis C
- HIV
- Hypertension (high blood pressure)
- Hypothyroidism (underactive thyroid)
- Kidney disease
- Learning disability
- Osteoporosis (thinning of bones)
- Peripheral arterial disease (circulation problems)
- Rheumatoid arthritis
- Serious mental health diagnosis (bipolar disorder, schizophrenia or other psychosis)
- Stroke or TIA (mini-stroke)

Have you been admitted to hospital in the last 12 months? Please give dates and diagnosis:

Additional medical information:

**Family history:** please tell us about any family illnesses that have affected your parents, brothers or sisters (and the age when they were first affected)

Heart attack or angina	Thrombosis (blood clots)
Stroke	Cancer
Diabetes	Other

**Women only:**

Are you on any form of contraception? If so, please state:

Date of most recent cervical smear: ..... Result of smear: .....

If age 50-65, date of last mammogram: .....

## Part 3 Ethnicity

The NHS is committed to helping all ethnic groups. In order to help the NHS pinpoint aid, would you please complete the following question. If you do not wish to divulge your ethnicity, please tick the box at the bottom of the page.

### What is your ethnic group?

Choose one section from A to E, and then tick the appropriate box to indicate your ethnic group.

#### A: White

- Scottish
- Other white British
- Irish
- Any other white background (please specify).....

#### B: Mixed

- White and black Caribbean
- White and black African
- White and Asian
- Any other mixed background (please specify).....

#### C: Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- Any other Asian background (please specify).....

#### D: Black or Black British

- Caribbean
- African
- Any other black background (please specify).....

#### E: Chinese or other ethnic group

- Chinese
- Any other (please specify)
- Do not wish to divulge ethnicity

### Language

What is your first language? .....

Do you speak English? Yes/No

Do you need an interpreter? Yes/No

British Sign Language? Yes/No

Makaton? Yes/No

### Disability

A disabled person is defined in the Disability Discrimination Act as someone with a physical or mental impairment that has a substantial and long-term impact on their ability to carry out day-to-day activities.

Having read this do you consider yourself to be covered by the definition? Yes/No

If yes, please state your disability:.....

# 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 ask for form GMSTRF001)

Date of Birth\*  -  -

Title\*

Surname\*

Forenames\*

Previous Surname\*

email address #

Address\*

Postcode\*

Telephone #

Mobile #

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

# 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\*

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:

Enlistment date\*  -  -

Are you a Reservist?\*  Yes  No

Leaving date\*  -  -

Is this your first registration with a GP since leaving the Armed Forces?\*  Yes  No

Service Number

If yes, please provide your address before enlisting\*

Postcode\*

## 3. VOLUNTARY CONSENT TO ORGAN 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.organdonation.nhs.uk](http://www.organdonation.nhs.uk).

Any of my organs and tissue  Or my

Kidneys  Eyes  Heart  Lungs  Liver  Pancreas  Small bowel  Tissue

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](http://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 Health Rights Information Scotland website at [www.hris.org.uk](http://www.hris.org.uk) 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