NEWBATTLE MEDICAL PRACTICE

REGISTRATION FORM - ADULTS

Newbattle Medical Practice www.newbattlemedicalpractice.co.uk
New Patient Questionnaire

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): Email address:	Home telephone number: 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
eg loratadine	*10mg*	*1 tab in the morning*	*hayfever*
……	……	……	
……	……	……	
……	……	……	
……	……	……	
……	……	……	
……	……	……	
……	……	……	
……	……	……	
……	……	……	

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-today 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

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

NHS SCOTLAND

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 3 months? Yes ☐ No

(If 'No', please complete a temporary resident form)

Male * ☐ Female *

Date of birth *

Title *

Surname *

Forenames *

Previous surname *

Address *

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 *(Scotland only)*

Mother's maiden name

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 *

Postcode *

Name and address of previous GP Practice in UK *

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

Leaving date *

If yes provide your address before enlisting *

Postcode *

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 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 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 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)

6. FOR PRACTICE USE

GP reference number

GP name

Practice code

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 HC2 cert ☐ Home Office app reg card ☐ Other / None

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 OFFICIAL USE ONLY

Input by

Checked by

Date

Practice stamp

Newbattle

Medical Practice

Dr Ansell / Dr Bailey / Dr I Morrison / Dr Glencross / Dr R Morrison / Dr Ma / Dr Read

SMS Text message consent form

Newbattle Medical Practice would like to offer you the ability to receive text message reminders for your appointments booked at the surgery. In the near future, we are also planning to send other health information out by SMS such as letting you know that your results are back, or that we need to get in touch with you. We might also occasionally send information about special clinics we are running that you might be interested in.

The SMS service should not be solely relied upon, as the responsibility of attending and cancelling appointments still rest with you, but we hope this will make things easier.

Messages are generated by an NHS secure service; however they are transmitted over a public network to a personal phone. **The practice will never transmit any information that would enable an individual patient to be identified, or specifically which tests they have had.**

Please tick the box below

☐ I **CONSENT** to the practice contacting me by text message for the purpose of health information and appointment reminders. I will ensure that **I keep the Informed of my up to date mobile number at all times, or if the number is No longer in my possession**

☐ Please note that you can **Opt-out** of receiving text messages from Newbattle Medical Practice at anytime by ticking this box.

Patient Name:	
Date of Birth:	
Mobile number:	
Signature:	
Todays date:	

We will NOT send out any texts unless you have explicitly consented

PRACTICE USE ONLY: SMS CONSENT TEMPLATE COMPLETED ☐

FORWARD FOR SCANNING ☐