

APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE

Drs Morrice, Masson & Geddes**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*	<input type="text" value="DD"/> - <input type="text" value="MM"/> - <input type="text" value="YYYY"/>	Address*	<input type="text"/>
Title*	<input type="text"/>		
Surname*	<input type="text"/>		
Forenames*	<input type="text"/>	Postcode*	<input type="text"/> <input type="text"/>
Previous Surname*	<input type="text"/>	Telephone #	<input type="text"/>
email address #	<input type="text"/>	Mobile #	<input type="text"/>

The following information can be found on your current medical card:

Community Health Index (CHI) Number*	<input type="text"/>	NHS Number*	<input type="text"/>
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The following information can be found on your birth certificate:

Town of Birth*	<input type="text"/>	Country of Birth*	<input type="text"/>
Registered district of birth (Scotland only)	<input type="text"/>	Mother's maiden name	<input type="text"/>

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*

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:

Enlistment date*	<input type="text" value="DD"/> - <input type="text" value="MM"/> - <input type="text" value="YYYY"/>	Service Number	<input type="text"/>
Are you a Reservist?*	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide your address before enlisting*	<input type="text"/>
Leaving date*	<input type="text" value="DD"/> - <input type="text" value="MM"/> - <input type="text" value="YYYY"/>		
Is this your first registration with a GP since leaving the Armed Forces?*	<input type="checkbox"/> Yes <input type="checkbox"/> No	Postcode*	<input type="text"/> <input type="text"/>

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.

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. 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 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



Dr Morrice Dr Masson Dr Geddes

Order Repeat Prescriptions

Book GP Appointments Online

These services are now available, hosted by Emis Patient Access, a secure system for you logging in to book routine appointments and order medications which are on repeat prescription. This means you can make these requests even outwith normal opening hours, from your PC or smartphone. If you wish to register for these services then please complete the form below and an email will be sent to you with the instructions. Alternatively, you can register on our website at:

<http://www.clarkstonmedicalcentre.co.uk/mmg-registration>

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Dr Morrice Dr Masson Dr Geddes

I wish to register for On Line Services;

My Name is..... D.O.B.....

My Email Address.....

Please list below other members of the household whom you wish to register, including a separate email address for any person at least 16 years old.

<u>Name</u>	<u>D.O.B.</u>	<u>Email</u>
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Drs Morrice, Masson & Geddes

New Patient Registration Form

This is a confidential questionnaire

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

Please bring a urine sample with you to your appointment – bottles are available from Reception

A separate form must be completed for each family member to be registered.

Have you ever been registered with Drs Morrice, Masson & Geddes before?

YES/NO

Your height:	Feet / inches		cm		Your weight:	Stones / lbs.		kg	
Your Religion:	C of S	Catholic	Other Christian (state)		Buddhist	Hindu	Muslim		
	Sikh	Jewish	Jehovah's Witness		No religion	Other religion (state)			
Your Ethnic Origin: (select one)		White (UK)		White (Irish)		White (Other)			
Caribbean		African		Asian		Other Mixed Background			
Indian / Brit Indian		Pakistani / Brit Pakistani		Bangladeshi / Brit Bangladeshi		Other Asian Background			
Other Black Background		Chinese		Other		Ethnic Category not stated			
Your main or 1st language Spoken / Understood: (select one)		English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi		
Polish	Ukrainian	French	German	Spanish	Other: (Please Specify)				
Your Medical Background:									
What illnesses have you had & When?									
What operations have you had and When?									

Do you have any medical problems at present?		
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)		
Are you able to administer your own medicines?	Yes	No – please detail specific issues (e.g. swallowing, opening containers)

Are there any serious diseases that affect your Parents or Brothers or Sisters (tick all that apply)	Diabetes	Heart Attack	Heart attack under age of 60	Bowel Cancer	
	Breast Cancer		High Blood Pressure	Asthma	Stroke
	Thyroid Disorder		Any other important Family Illness?		

What immunisations have you had? (please tick all that apply)	Diphtheria	Tetanus	Polio	Measles	German Measles	MMR
	Whooping Cough		Pre-school booster		Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses	

Have you nominated someone to speak on your behalf (e.g. a person who has Power of Attorney)?	Yes / No	If “Yes”, please state their name / address / phone number:

Children under 16:	
Which school does your child attend?	

Women only:				
When was your last smear done?	Date	Was this at your GP's Surgery?	Yes	NO
What was the result of the smear?				
Date of last mammogram (if applicable):	Date	Method of contraception (if used):		
Do you wish to see a doctor in this practice for contraceptive services (including the pill, coil or cap)?			Yes	NO

LIFESTYLE

ALCOHOL

The FAST Test

1. How often do you have eight or more drinks on one occasion?

☐ Never ☐ Less Than Monthly ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

☐ Never ☐ Less Than Monthly ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

3. How often during the last year have you failed to do what was normally expected of you because of your drinking?

☐ Never ☐ Less Than Monthly ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

4. Has a relative or friend, a doctor or other health worker been concerned about your drinking or suggested you cut down?

☐ No ☐ Yes, but not in the last year. ☐ Yes in the last year.

Score _____ (the nurse will complete this for you)

SMOKING ADVICE

Do you smoke? Yes / No

If Yes, how many:

Cigarettes per day Cigars per day Ounces of tobacco per day

How old were you when you started smoking?

EX-SMOKERS

How old were you when you stopped smoking?

How much did you smoke per day?

PASSIVE SMOKING

Are you exposed to smoke at work? Yes / No At home? Yes / No

We think it is important to advise each of our patients about the health hazards of smoking, which include an increased risk of:

Lung Cancer Coronary Heart Disease Peripheral vascular disease
Bronchitis and Emphysema Cervical Cancer Mouth and throat cancer
Difficulty conceiving (men and women) Miscarriage Low birth weight babies
Chest problems in the children of smokers

All the local pharmacies offer smoking cessation support, please tick the circle to show you have acknowledged this: ☐

EXERCISE

Do you take regular exercise? Yes / No

If yes, what sort of exercise?

How many times per week?

ALLERGIES

Are you allergic to any medication or foods? Yes / No

If yes, please give details:

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.....

Do you have any other allergies?

Yes/No

If yes, please give details:

.....
.....

Patient Signature:		Signature on behalf of Patient:	
Date		Date	
GP Cipher		Practice Code	G49214
GP Name &Signature		Date	

Thank you for completing this form

Clinical Section – to be completed by the Nurse at your appointment

Urinalysis

Height

Weight

BP
