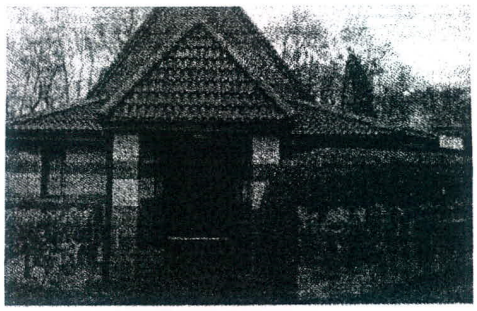

SPRINGFIELD
MEDICAL PRACTICE

Dr R Macmillan Dr L Boyce Dr K Lapsley

Dr M Robinson Dr J Hoyle

Practice Notice

Please be aware this is a busy practice, routine appointments are approximately **3 weeks in advance**.

Please ensure you receive a **2 month's supply of medication** from your previous practice to allow timescale of registering.

Thank You.

Please ensure you bring I.D when handing in your application.

9 Springfield Road Bishopbriggs G64 1PJ
Tel: 0141-772-4744

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 #

Mobile #

Email address #

 # 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

NEW PATIENT INFORMATION SHEET

PATIENT DETAILS

Name _____ Date of Birth _____

Address _____ Telephone Number _____

_____ Occupation _____

_____

NEXT OF KIN

Name _____ Telephone Number _____

Address _____ Relationship _____

_____

*** If you are registering a child under 16 please let us know if you want to receive text reminders for their appointments.***

YES □ NO □

Previous doctor _____

Address of Practice _____

PAST MEDICAL HISTORY

_____

Have you had a Blood Transfusion BEFORE 1996? Yes/No

MEDICATION

Please state any treatment you are on at present

_____

_____

FAMILY HISTORY

Have parent or near relatives ever suffered from:

HEART DISEASE _____ **STROKE** _____

HIGH BLOOD PRESSURE _____ **DIABETES** _____

(Please state relationship to yourself)

LIFESTYLE: SMOKING _____PER DAY ALCOHOL_____PER WEEK EXERCISE_____PER WEEK

ALLERGIES

NEW DATA PROTECTION LAW

We use various systems to communicate with you regarding your health and under the new General Data Protection Regulation Guidelines we can continue to do this if it relates to your health. We may also contact you regarding your appointments, general health campaigns and to share practice information. This could be via text message, email, letter or phone

Please tick all options indicating how you wish the practice to communicate with you:

Text Message □ Email □ Letter □ Mobile Phone □ Landline □

Patient Signature _____

PATIENT QUESTIONNAIRE
SPRINGFIELD MEDICAL PRACTICE

This short questionnaire will give the Practice Team some basic information about your communication support needs and ethnicity to support your health care. More information about it is available please ask a member of staff if you need more explanation.
We should be grateful if you could complete one for each family member within/joining the Practice.

Name _____ **DOB** ____ / ____ / _____

Do you need an interpreter or sign language support? ☐Yes ☐No

If you do need an interpreter what language do you speak?

Please state _____

What is your ethnic group?
Choose **ONE** section from A to E then tick **ONE** box which **best describes** your ethnic group or background

A White
- ☐ Scottish
- ☐ English
- ☐ Welsh
- ☐ Northern Irish
- ☐ British
- ☐ Irish
- ☐ Gypsy/Traveller
- ☐ Polish
- ☐ Any other white ethnic group, please write in.....

B Mixed or multiple ethnic groups
- ☐ Any mixed or multiple ethnic groups

C Asian, Asian Scottish or Asian British
- ☐ Pakistani, Pakistani Scottish or Pakistani British
- ☐ Indian, Indian Scottish or Indian British
- ☐ Bangladeshi, Bangladeshi Scottish or Bangladeshi British
- ☐ Chinese, Chinese Scottish or Chinese British
- ☐ Other, please write in.....

D African, Caribbean or Black
- ☐ African, African Scottish or African British
- ☐ Caribbean, Caribbean Scottish or Caribbean British
- ☐ Black, Black Scottish or Black British
- ☐ Other, please write in.....

E Other ethnic group
- ☐ Arab
- ☐ Other, please write in.....

If you do not wish to give this information, please tick here ☐

ARE YOU A CURRENT SMOKER? YES ☐ NO ☐ EX SMOKER ☐

IF YES, WOULD YOU LIKE SOME SMOKING CESSATION ADVICE POSTED OUT? YES ☐ NO ☐