GPR

NHS IN SCOTLAND

APPLICATION TO REGISTER PERMANENTLY WITH A GENERAL MEDICAL PRACTICE

Please use **BLOCK CAPITALS** to complete the form and tick all relevant boxes

PERSONAL DETAILS (ALL FIELDS MARKED * ARE MANDATORY AND MUST BE COMPLETED AS FULLY AS POSSIBLE)

Eligibility to use the NHS services depends mainly on residence in the UK, and on other qualifying provisions set out in the Regulations. By completing this section fully, you will assist us in processing your application and locating any existing medical records promptly.

WILL YOU BE IN THE AREA FOR MORE THAN THREE MONTHS?* YES ☐ NO ☐

IS THIS YOUR FIRST REGISTRATION WITH A GP PRACTICE?* YES ☐ NO ☐

SURNAME *

TITLE #

MALE * ☐ FEMALE * ☐

FORENAME *

MIDDLE NAME *

PREVIOUS SURNAME *

DATE OF BIRTH *
D D M M Y Y Y Y

ADDRESS *

POSTCODE *

TOWN & COUNTRY OF BIRTH *

MOTHER'S MAIDEN NAME *

TELEPHONE NUMBER #

EMAIL ADDRESS #

PREVIOUS ADDRESS IN UK *

POSTCODE

NAME AND ADDRESS OF PREVIOUS REGISTERED GP PRACTICE IN UK *

POSTCODE *

COMMUNITY HEALTH INDEX NUMBER

NHS NUMBER

NATIONAL INSURANCE NUMBER

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.

ARE YOU RETURNING / HAVE YOU ARRIVED FROM ABROAD OR HM FORCES? * YES ☐ NO ☐

DATE OF DEPARTURE FROM UK D D M M Y Y

DATE OF ENTRY/RETURN TO UK D D M M Y Y

IF RETURNING FROM H M FORCES DATE ENLISTED D D M M Y Y

SERVICE/PERSONNEL NO.

COUNTER FRAUD 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 the Common Services Agency to confirm my eligibility to lawfully register with a GP and for the purposes of prevention, detection, and investigation of crime, I consent to the disclosure of relevant information from this form including to and by the NHS Business Services Authority, the Common Services Agency, UK Border Agency, Identity and Passport Service, the Department for Work & Pensions, HM Revenue and Customs, the General Register Office and Local Authorities.

PATIENT OR REPRESENTATIVE SIGNATURE

_____ DATE D D M M Y Y

IF SIGNING AS A REPRESENTATIVE, PLEASE STATE:

YOUR NAME

YOUR RELATIONSHIP TO THE PATIENT

VOLUNTARY CONSENT TO ORGAN DONATION

I authorise the donation of (Please tick the boxes that apply)

A. any of my organs and tissue ☐ or my

B. kidneys ☐ heart ☐ liver ☐ small bowel ☐

eyes ☐ lungs ☐ pancreas ☐ tissue ☐

for transplantation after my death D D M M Y Y

PATIENT SIGNATURE _____ DATE

PRACTICE ACCEPTANCE AGREEMENT – for GP Practice use only

PRACTICE CODE

GP NAME

GP REFERENCE NUMBER

IDENTIFICATION SEEN

MEDICAL CARD ☐ BIRTH CERTIFICATE ☐ PASSPORT ☐ OTHER - SPECIFY

I accept this patient onto the practice list and declare that, to the best of my knowledge the information I have given on this form is correct and complete and I understand that if it is not, action may be taken against me. I acknowledge that the details may be authenticated from appropriate records, and that payments generated from this patient registration will be made to my Practice, which will be subject to Payment Verification. Where Common Services Agency is unable to obtain authentication, I acknowledge that the onus is on my Practice to provide documentary evidence to support this application.

GP SIGNATURE _____ DATE D D M M Y Y

OFFICIAL USE ONLY		
Input By:	Date:	Checked By: