

## How to Register with Dollar Health Centre

### ***Patient registration for patients between 5 years old and up to and including 14 years old***

Please complete the form “Application to register permanently with a General Medical Practice” as fully as possible. If you don’t know some of the information, don’t worry, but please let reception know about this when you hand the forms in. All boxes marked with a \* **must be completed**.

#### **Check List**

- Have you completed and signed the “*Application to register permanently with a General Medical Practice*” form on behalf of your child
- Have you completed the “*New Patient Questionnaire Sheets*” on behalf of your child
- Have you signed that you have received a copy of “Your Information – Uses and Protection” on the “*New Patient Questionnaire Sheets*” on behalf of your child
- Have you signed the form at the “counter fraud declaration” section?
- If you’ve indicated you want us to record your consent to organ donation, have you signed the section “voluntary consent to organ donation” in addition to the “counter fraud declaration” section?
- When handing the forms in, please provide proof of identification. Photographic is preferable but a birth certificate is acceptable

# 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*    | <input type="text" value="DD"/> - <input type="text" value=""/> - <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"/> |
|--------------------------------------|----------------------|-------------|----------------------|

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* | Name and address of previous GP Practice in UK*     |
| <input type="text"/>                                   | <input type="text"/>                                |
| Postcode* <input type="text"/> <input type="text"/>    | Postcode* <input type="text"/> <input type="text"/> |

### If you are from abroad:

|  |   |  |   |
|--|---|--|---|
| Date you first came to live in the UK* | <input type="text" value="DD"/> - <input type="text" value=""/> - <input type="text" value="YYYY"/> | If previously resident in the UK, date of leaving* | <input type="text" value="DD"/> - <input type="text" value=""/> - <input type="text" value="YYYY"/> |
| Your most recent country of residence  | <input type="text"/>  |  |   |

### If you have served in the British Armed Forces:

|  |   |   |   |
|--|---|---|---|
| Enlistment date*   | <input type="text" value="DD"/> - <input type="text" value=""/> - <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=""/> - <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](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

**Dollar Health Centre – New Patient Questionnaire – Page 1**  
**For patients between 5 years old and up to and including 14 years old**

Please complete this questionnaire as fully as possible.

|                                |
|--------------------------------|
| Name _____ Date of Birth _____ |
|--------------------------------|

Have you ever been seen at Dollar Health Centre before? Yes / No

Name known by

|                          |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--------------------------|--|
| Mr                       | Mrs                      | Miss                     | Ms                       | Other  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input style="width: 150px; height: 20px;" type="text"/> |

|  |  |
|--|--|
| Telephone Number   | Mobile Number  |
| <input style="width: 350px; height: 20px;" type="text"/> | <input style="width: 350px; height: 20px;" type="text"/> |

If new baby – Mother’s Name

**Ethnicity** – we hope that you do not mind completing this section, there may be cultural issues in relation to healthcare that we should be aware of.

|   |             |                              |                    |
|---|-------------|------------------------------|--------------------|
| I would describe my ethnicity as (please circle one): |             |                              |                    |
| White Scottish  | Indian      | African                      | Other              |
| White British   | Pakistani   | Black or Black Scottish      | White Irish        |
| Bangladeshi   | Other Asian | Caribbean                    | Other Ethnic Group |
| Other White   | Chinese     | Any mixed background         |                    |
| Country of Birth:                                     |             |                              |                    |
| UK  | Other EEC   | Other (Please specify) _____ |                    |

|   |            |
|---|------------|
| I acknowledge receipt of the Information Sheet – “Your Information – Uses and Protection” |            |
| Signature _____   | Date _____ |

**Dollar Health Centre – New Patient Questionnaire – Page 2**  
**For patients between 5 years old and up to and including 14 years old**

**Health History (Please list any illnesses that may be applicable to your child)**

|               |         |                     |         |
|---------------|---------|---------------------|---------|
| Heart Disease | Yes /No | Stroke / CVA        | Yes /No |
| Diabetes      | Yes /No | High Blood Pressure | Yes /No |
| Asthma        | Yes /No |                     |         |

|                                      |         |
|--------------------------------------|---------|
| Have you had any infectious disease? | Yes /No |
| Please list with approximate dates   | Date    |
|                                      |         |
|                                      |         |
|                                      |         |

Please tell us about current conditions, past illnesses, accidents, operations or other hospital admissions including if possible a date or what age you were.

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**Medication**

Please list all medication that you take. Please include any medication, which is bought from the chemist.

| <b>Name</b> | <b>Dose</b> | <b>Name</b> | <b>Dose</b> |
|-------------|-------------|-------------|-------------|
| -----       | -----       | -----       | -----       |
| -----       | -----       | -----       | -----       |

Does the child have any allergies? Yes / No  
 Which if any .....

**Family History (Do either of your parents have/had?)**

|               |          |           |        |          |           |
|---------------|----------|-----------|--------|----------|-----------|
| Heart Disease | Yes / No | Mum / Dad | Stroke | Yes / No | Mum / Dad |
| Diabetes      | Yes / No | Mum / Dad | Asthma | Yes / No | Mum / Dad |
| Hypertension  | Yes / No | Mum / Dad |        |          |           |

## Carers and Being Cared For

**The practice offers support and assistance to carer/s, and recognises the invaluable role they take in helping those being cared for, and we would ask assistance in identifying and supporting carers.**

A carer is someone irrespective of age, who provides or supervises a substantial amount of care on a regular basis of a child, relative, partner or neighbour who is unable to manage on their own due to illness, disability, frailty, mental distress or impairment.

The term "carer" would not apply if the person is either a paid carer, a volunteer from a voluntary agency or anyone providing personal assistance for payment either in cash or kind.

We would be grateful if you would answer the following questions.

### Carer:

Do you care for someone? (as described in paragraph 2 above) Yes / No

Do we have your permission to include your name on our carers register and to undertake periodic review of your well-being and support that you may need? Yes / No

What is your relationship with the person being cared for \_\_\_\_\_

Is the person registered with this practice? Yes / No

**Under the data Protection Act 1998, we also need the permission of the person being cared for before recording their name.**

Can you advise us of the name and address of the person being cared for

Name \_\_\_\_\_

Address \_\_\_\_\_

We would be grateful if when you undertake or cease a carer role that you advise a member of the primary care team. This will allow us to maintain up to date medical records.

We work closely with the Princess Royal Trust for Carers and will pass new carers information onto them. If you do not want us to pass on your details please tick box below

I do not want my details passed to the  
Princes Royal Trust For Carers

### **Carer Health Reviews**

We offer all carers an annual health review with one of the GP's in the practice. If you would like a review, please tick this box

## Being Cared For

Carers can play a significant role in the lives of the people they care for and it helps us to look after you if we know of others involved in helping you with your daily living.

A carer is someone, irrespective of age, who provides or supervises a substantial amount of care on a regular basis to a child, relative, partner or neighbour who is unable to manage on their own due to illness, disability, frailty, mental distress or impairment.

It doesn't matter if the carer is a friend or relative or a voluntary or paid person or organisation, if you have someone who helps you with your daily living activities please answer the questions below.

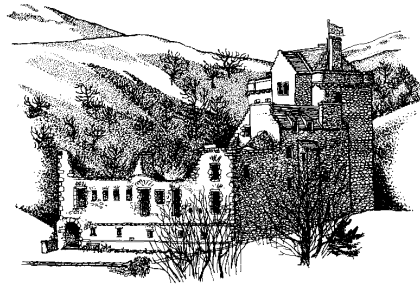
|   |          |
|---|----------|
| Do you have a carer? (as described in paragraph 2 above)  | Yes / No |
| Do we have your permission to record in your medical records that you have a carer?   | Yes / No |
| What is your relationship with your carer? _____  |          |
| Is the carer registered with this practice?   | Yes / No |
| <b>Under the data Protection Act 1998, we also need the permission of the carer before recording their name in your medical record.</b> |          |
| Please advise us of the name and address of the carer below   |          |
| Name _____  |          |
| Address _____   |          |
| _____   |          |

**We will not discuss any aspect of your medical treatment or care with your carer unless we have your permission to do so.**

**We would be grateful if you would advise a member of the primary care team if you start or stop having a carer.**

Thank you for taking the time to fill in this questionnaire.  
Dollar Health Centre, Park Place, Dollar, FK14 7AA.  
Telephone Number 01259 742120.

**Dr N M Houston**  
**Dr P M Baughan**  
**Dr H F Randfield**  
**Dr G M Meeten**



**Dollar Health Centre**  
**Park Place**  
**Dollar**  
**FK14 7AA**

**Tel: 01259 742120**  
**Fax: 01259 743053**

Thank you for choosing to join this practice, we look forward to a helping you to achieve the best health possible.

Patients have said that they want to take ownership of their medical care and that the partnership that you are entering into with the practice is most effective when based on trust and openness. These are sentiments that everyone working at the practice agrees with.

The content of the medical records that we receive from your previous practice is used as a basis for your ongoing medical care and we invite you to view a summary of your medical record when it is received from your last practice. This will give you an opportunity to review the content for accuracy and completeness and to add, query or correct any information contained within it.

If you would like to review your record please complete the details below and hand this back with your registration and new patient forms. If you would like to discuss this invitation or have any comments please contact me.

Yours sincerely

**Steven R Ebsworth**  
**Practice Manager**

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Name \_\_\_\_\_ Date of birth \_\_\_\_\_

I would like to review the summary of my medical records when they arrive

**My preferred method of receiving this summary is:**

\*by email \_\_\_\_\_ please give your email address

by personal collection from the health centre

Please note that if you prefer to receive your summary by:

- email, they are **NOT** sent over encrypted systems and the risk lies with you to ensure your email address is written clearly and correctly
- by post, they are sent 2<sup>nd</sup> class normal royal mail delivery





## “Your Information – Uses and Protection”

**We are registered with the Information Commissioner and our Data Controller is Dr Neil Houston.**

### **What Information Do We Hold?**

We hold data relevant to your medical care, and can include personal details, a record of your appointments and consultations, prescribed medications, test results, lifestyle and employment information.

### **Who Has Access?**

In addition to your doctors, the practice nurses, district nurses, health visitors and administration staff working at the health centre have access to your medical information.

Other attached medical professionals who have access to information about you are:

Visiting Colleagues offering specialist medical and support services, for example:

- Physiotherapist, Podiatrist
- Clinical Guidelines Coordinator
- Medical and Nursing Students

**but only in relation to the care they are providing.**

### **Sharing Information**

Telephone calls made to NHS24 are recorded. A summary of the care you receive from NHS24 and the Out of Hours service is retained on a clinical system used by this organisation and a copy is in your medical record at this practice.

Everyone working for the NHS has a legal duty to keep information about you confidential. Great care is taken to ensure that confidentiality is maintained in respect of all information held about you.

If you are receiving care from other medical professionals or other organisations, we can provide information relevant to the care you are receiving.

### **How is the information used?**

In addition to using the information to provide you with proper and appropriate care and treatment, both the wider NHS and the Practice keep information relating to our activities.

Information is collated and used to plan health services (statistical anonymous data only) and to provide protection and monitoring of public health, investigate complaints, and to ensure quality of your care and treatments and to provide evidence of best practice.

The medical care and treatment you receive is audited, monitored and reviewed. Information specific to you is used to monitor your health, and used to audit the care we provide to our patients.

Although we may be using your information or asking you about treatment received, when the audit or report is completed all of the details which could identify you have been removed.

### **Verification of Services**

To ensure propriety and fiscal accountability a central NHS body called Practitioner Services can at times audit the practice.

To ensure that we are claiming correctly, Practitioner Services may contact patients to confirm that they have received the service claimed.

### **Access to Health Records**

The Data Protection Act (1998) gives you the right to access your health records both manual and computer records. Only in very exceptional circumstances can access be withheld.

Without your consent, no other person or organisation can access your records. With the exception of legal and statutory obligations, the only circumstances when information may be provided about you would be if the release of the information would be in the interest of the greater public good.

For example notification to DVLA of a medical condition which would preclude you from driving.

Applications for accessing your records must be made in writing and sent to the Practice Manager. There may be a charge for this service.

### **Training**

All doctors, nurses and staff receive annual training on confidentiality and data protection.

For more information please speak to the Practice Manager.