

Welcome to Our Practice

Dr ANGELA DUNN
DR EILEEN MCAULAY
DR MOYNA AROKIANATHAN

Dr JILL FOWLIE
Dr STEWART MCMENEMIN
DR KASHIF ALI

Dr VIMAL S AMIN
DR SUMI ROY

As it takes some time for your medical records to reach us from your previous doctor, please complete the questions on this form and return it to the practice along with any prescription re-order forms and your registration form

When arranging your first ever GP appointment at the surgery please request a double appointment.

If you fail to keep your first appointment with the practice you will no longer be offered registration here.

NAME

Date of Birth

Occupation.....

Language(s) spoken.....

Next of Kin

Telephone No.

Next of Kin Contact Number.....

E-Mail address.....

Marital Status.....

Mobile No.....

PLEASE ATTACH COMPLETE CURRENT MEDICATION LIST AND BRING TO FIRST APPOINTMENT

ARE YOU ALLERGIC TO ANY MEDICINES, IF SO WHICH ONES?

Past Medical History and approx date of diagnosis:

Hospital/Outpatient Clinics attended?

Family History (please list any history of Heart Disease, Diabetes, Cancers in parents, brothers or sisters and approximate age of onset)

SMOKING HISTORY CURRENT (HOW MANY PER DAY ()) EX-SMOKER NEVER SMOKED

IF YOU SMOKE WOULD YOU LIKE SOME HELP TO STOP

ALCOHOL UNITS PER WEEK

HEIGHT WEIGHT

DR DUNN AND PARTNERS OPERATES A TEXT MESSAGE SERVICE TO CONFIRM AND REMIND YOU OF YOUR APPOINTMENTS AT THE SURGERY. THIS WILL ALSO BE USED TO CONTACT YOU FOR OTHER PURPOSES FOR EXAMPLE TO INFORM YOU OF BLOOD TEST RESULTS OR TO INVITE FOR FLU VACCINATIONS OR CHRONIC DISEASE REVIEW (IF ELIGIBLE). PLEASE TICK THE BOX TO CONFIRM YOU GIVE CONSENT TO BE CONTACTED VIA TEXT MESSAGE .

Welcome to Our Practice

General Data Protection Regulation. Patient Information Notice.

As a practice we need to hold personal information about you on our computer system and in paper records to help us to look after your health needs. Your doctor is responsible for their accuracy and safe-keeping. Please help to keep your record up to date by informing us of any changes to your circumstances.

Doctors and practice staff have access to your medical records to enable them to do their jobs. From time to time information may be shared with others involved in your care. Anyone with access to your record is properly trained in confidentiality issues and is governed by both a legal and contractual duty to keep your details private. All information about you is held securely and appropriate safeguards are in place to prevent accidental loss. We keep your personal information securely for as long as we need to.

In some circumstances we may be required by law to release your details to statutory or other official bodies, for example if a court order is presented, or in the case of public health issues. In other circumstances you will be required to give written consent before information is released – such as for medical reports to insurance agencies or solicitors and also if you request copies of your medical records.

To ensure your privacy, we will not disclose information over the telephone or fax unless we are sure that we are talking to you. Information will not be disclosed to family, friends or spouses unless we have prior written consent, and we do not leave messages with others.

You have a right to see your records if you wish. An appointment will be required. Please ask at reception if you would like further details.



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"/> - <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*	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"/> - <input type="text" value="YYYY"/>	If previously resident in the UK, date of leaving*	<input type="text" value="DD"/> - <input type="text"/> - <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"/> - <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"/> - <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 <input type="checkbox"/>	Eyes <input type="checkbox"/>	Heart <input type="checkbox"/>	Lungs <input type="checkbox"/>	Liver <input type="checkbox"/>	Pancreas <input type="checkbox"/>	Small bowel <input type="checkbox"/>	Tissue <input type="checkbox"/>
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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

Drs Dunn, Fowlie, Amin, McAulay, McMenemy, Roy Arokianathan and Ali

162 Nithsdale Road
Glasgow
G41 5RU
Tel: 0141 424 1831 Fax: 0141 423 7422

4-6 Merryvale Place
Giffnock
G46 6AT
Tel: 0141 633 2486 Fax: 0141 633 3527

ONLINE SERVICES REGISTRATION FORM

NAME.....

DATE OF BIRTH.....

ADDRESS.....

.....

.....

.....

PHONE NUMBER.....

EMAIL ADDRESS.....

SIGNATURE.....

DATE.....

TERMS AND CONDITIONS

The Practice retains the right to remove your ability to order prescriptions online at anytime.

Please note, prescriptions will be ready for collection in 48 hours. Please specify where you wish to collect your prescription at the time of ordering, using the text box provided on the website.

If you are under 16 years of age, you may still use this service, if this form is completed by a parent or guardian. However, upon turning 16, the Practice will remove your ability to order online for confidentiality reasons. You must then re-register yourself.

The Practice is not responsible for your log in details. If you lose your pin number for ordering prescriptions, the Practice can generate a form to create a new one, but it is your responsibility to keep this safe. No account log in details are held by the Practice.

Please note, that any requests submitted via the website either for repeat or specially requested medications, are not guaranteed. Special requests for medication previously given but not on your repeat medication list will only be issued where clinically appropriate.

When you have completed this registration form, the Practice will generate the form required for you to register online within 7 days. Please provide an email address above clearly and we will email this to you.

Completion of this form for yourself, or on behalf of a minor, is indication of your wish to apply for online prescription ordering.

Please visit our website at <http://www.nithsdalemerryvalesurgery.co.uk>