**Kilsyth Medical Partnership – Temporary Resident Registration Form**

*PLEASE COMPLETE IN BLACK INK AND BLOCK CAPITALS*

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| Male Female Title: MR / MRS / MISS / MS / MX/ DR / OTHER \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Full Name: |  | | | | |
| Date of Birth: |  | | | | |
| CHI Number: |  | NHS Number: | | |  |
| Have you been seen at this practice before? Yes No | | | | | |
| If yes, when? |  | | | | |
| Temporary Address:  Post Code: |  | | | | |
| Contact Telephone Number(s): |  | | | | |
| Length of Stay: | Less than 16 days | | 16 days to 3 months | | |
| Date Returning Home: |  | | | | |
| Home Address:  Post Code: |  | | | | |
| Own Doctor’s Name & Address:  Post Code: |  | | | | |
| Own Doctor’s Telephone Number: |  | | | | |
| Signature: |  | | | Date: | |

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| Medical History - please help us by listing as much information as possible | |
| Do you have any medical conditions? (i.e. diabetes, heart disease, asthma, hypertension) | Yes / No If yes, please provide details: |
| Are you currently taking any medication? | Yes / No If yes, please list what medication you are taking: |
| Do you have any allergies? | Yes / No If yes, please provide details: |

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| **FOR STAFF USE ONLY** | Staff name: |
| Type of ID provided: | Date: |