**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: |