**New Patient Registration Form CHILD UNDER 16** Please complete all pages in full using block capitals

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| **1. Background Details** |

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| **Contact Details** | | | | |
| NHS Number |  | | *If you have had a previous GP then you will find this on letters/prescriptions or at* [www.nhs.uk/find-nhs-number](https://eur01.safelinks.protection.outlook.com/?url=http%3A%2F%2Fwww.nhs.uk%2Ffind-nhs-number&data=04%7C01%7Csupport%40ardens.org.uk%7Cffabf11787fb41dc43be08d99fa70d67%7C2574bae132844b5a8833850acab88d43%7C1%7C0%7C637716362095841893%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=MF3g4y6zrx4E0Qifat%2FgKNmjXrzmgNeU5ebPuaEcNAo%3D&reserved=0) | |
|  | I do not know my NHS number | |  | |
| Name |  | | Gender |  |
| Which of the following best describes how you think of yourself? | Non-binary Female Male Prefer not to say Unable to answer | | | |
| Is your gender the same as the sex you were assigned at birth? | Yes Prefer not to say  No Unable to answer | | | |
| Previous Surname  (if applicable) |  | | | |
| Address |  | | Date of Birth |  |
| Home Telephone |  |
| Work Telephone |  |
| Previous Address |  | | | |
| Mobile Telephone | I consent to be contacted\* by SMS on this number: | | | |
| Email | I consent to be contacted\* by email at this address: | | | |
| Family Registered With Us | |  | | |
| Has the patient been registered in the NHS before?  Yes  No  If no please state date entered UK: | | | | |

**\* It is your responsibility to keep us updated with any changes to your telephone number, email & postal address. We may contact you with appointment details, test results, health campaigns or Patient Participation Group details. If you do not consent to being contacted by SMS or Email, please tick here:  SMS  Email**

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| **Other Details** | | | | | |
| Previous GP | Name: | | Address: |  | |
| Country of Birth |  | | | | |
| Ethnicity | White (UK)  White (Irish)  White (Other) | Black Caribbean  Black African  Black Other | | Bangladeshi  Indian  Pakistani | Chinese  Other |
| Religion | C of E  Catholic  Other Christian | Buddhist  Hindu  Muslim | | Sikh  Jewish  Jehovah’s Witness | No religion  Other: |
| Housing | Own House  Rented House  Shared House | Nursing Home  Residential Home  Sheltered Home | | Homeless  Housebound | Asylum Seeker  Refugee |

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| **Communication Needs** | | | |
| Language | What is your main spoken language?  Do you need an interpreter?  Yes  No | | |
| Communication | Do you have any communication needs?  Yes  No (If **Yes** please specify below) | | |
| Hearing aid  Lip reading | Large print  Braille | British Sign Language  Makaton Sign Language  Guide dog |
| Learning disability | Do you have a Learning Disability?  Yes  No  (If **Yes** please request a Learning Disability Screening Tool form) | | |

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| **Carer Details** | | | | | |
| **Are you** a carer? | Yes – Informal / Unpaid Carer | | Yes – Occupational / Paid Carer | | No |
| Do you **have** a carer? | Yes | Name\*: | Tel: | Relationship: | |

*\* Only add carer’s details if they give their consent to have these details stored on your medical record*

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| **Next Of Kin** |
| Title: Gender: 🞏 Male 🞏 Female  Full name:  Tel. contact number: Relationship: |

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| **2. Medical History** |

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| **Medical History** | | | |
| Have you suffered from any of the following conditions? | | | |
| Asthma  Epilepsy |  | Diabetes | Depression |
| Any other conditions, operations or hospital admission details:  If you are currently under the care of a Hospital or Consultant outside our area, please tell us here: | | | |

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| **Family History** | | | |
| Please record any significant family history of close relatives with medical problems and confirm which relative e.g. mother, father, brother, sister, grandparent | | | |
| Asthma………………….  COPD………………...…  Epilepsy………………… | Heart Disease……….…  Stroke…………….……..  Blood Pressure………… | Diabetes………..………  Kidney Disease..………  Liver Disease..….…….. | Depression………..……  Thyroid…………..….…..  Cancer………………….. |
| Other: | | | |

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| **Allergies** |
| Please record any allergies or sensitivities below |

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| **Current Medication** |
| Please check and include as much information about your current medication below  Please give us your previous repeat medication list if possible and a medication review appointment may be needed |

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| **Further Details** |

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| **Education** |
| Does <patient name> go to any of the following for their education? |
| Nursery school secondary school junior school  Primary school boarding school home tuition |

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| **Electronic Prescribing** | |
| If you would like your prescriptions to be sent electronically,  please provide details of the pharmacy you would like to use: | Pharmacy: |

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| **Parent or Guardian Signatures** | |
| Signature | I confirm that the information I have provided is true to the best of my knowledge. |
| Name |  |
| Date |  |

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| **5. Sharing Your Health Record** |

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| **Your Health Record** |
| Do you consent to your GP Practice sharing your health record with other organisations who care for you?  Yes *(recommended option)*  No, never  Do you consent to your GP Practice viewing your health record from other organisations that care for you?  Yes *(recommended option)*  No |

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| **Your Summary Care Record (SCR)** |
| Do you consent to having an Enhanced Summary Care Record with Additional Information?  Yes *(recommended option)*  No |

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| **Parent or Guardian Signature** | |
| Signature |  |
|  | Signed on behalf of patient |
| Name |  |
| Date |  |