**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 sayNo 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 [ ]  NoIf 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 🞏 FemaleFull 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 belowPlease 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, neverDo 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 |  |