**New Patient Registration Form - Child**

Please complete all pages in full using block capitals

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| **1. Background Details** |

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| **Your Child 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) | |
| Child Name |  | Gender |  |
| Address |  | Date of Birth |  |
| Home Telephone |  |

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| **Parent or Guardian Details** | | | | |
| Your Name |  | | Relationship |  |
| Address |  | | Home Telephone |  |
| Work Telephone |  |
| 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 | |  | | |

*\* 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 or 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 |  | | | | |
| School |  | | | | |
| Ethnicity | White (UK)  White (Irish)  White (Other) | Black Caribbean  Black African  Black Other | | Bangladeshi  Indian  Pakistani | Arabic  Chinese  Other |
| Religion | C of E  Catholic  Other Christian | Buddhist  Hindu  Muslim | | Sikh  Jewish  Jehovah’s Witness | No religion  Other: |
| Housing | Own Home  Rented Home | Shared House  Sheltered House | | Asylum Seeker  Refugee |  |
| Overseas Visitor | Yes | European Health Insurance Card Held (please bring details with you) | | | |
| Armed Forces | Family Member |  | |  |  |

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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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| **2. Medical History** |

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| **Medical History** | | | |
| Has your child suffered from any of the following conditions? | | | |
| Asthma | Depression | Diabetes | Epilepsy |
| Any other conditions, operations or hospital admission details:  If your child is 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 attach if possible a copy of your repeat prescription request and include any other medication you may be taking which does not appear on your list. PLEASE NOTE AN APPOINTMENT WITH THE GP MAY BE NECESSARY FOR A MEDICATION REVIEW. |

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| **3. Further Details** |

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| **Named Accountable GP** | |
| The GP who has overall responsibility for your child’s care is |  |

*You are however entitled to make an appointment to see any GP of your choice, subject to availability.*

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| **Electronic Prescribing** | |
| If you would like your child’s prescriptions to go electronically,  please provide details of the pharmacy you would like to use: | Pharmacy: |

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

**Checklist**

Please ensure the following are done and provided so that your registration can be completed successfully

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|  | Completed & Signed Above Form |
|  | Completed & Signed GMS1 Form |
|  | Birth Certificate |
|  | Photo Proof of ID e.g. Passport, Photo Driving License or Photo ID card |
|  | Proof of Address e.g. Bank statement, Utility Bill or Council Tax from within the last 3 months |

**Practice Use Only**

|  |  |  |  |  |
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| Appointment | Required | Not Required |  |  |
| Photo ID | Passport | Driving licence | Identity card | Other |
| Proof of Address | Utility Bill | Council Tax | Bank Statement | Other |

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| **4. Sharing Your Health Record** |

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| **Your Health Record** |
| Sharing Out  Do you consent to your GP Practice sharing your Child’s health record with other organisations who care for them?  Yes *(recommended option)*  No  Sharing In  Do you consent to your GP Practice viewing your Child’s health record from other organisations that care for them?  Yes *(recommended option)*  No |

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

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| **Parent or Guardian Signature** | |
| Signature |  |
| Name |  |
| Date |  |