New Patient Registration Questionnaire: Under 12's

It can take several weeks to obtain your original notes, and any information you can provide will assist the doctors and nurses in assessing the patients' needs and offering the appropriate healthcare.

Please bring a full birth certificate and proof address with you when returning this form.

Surname:	
First name:	
Date of birth:	
Home Telephone:	
Mobile Telephone:	
Email:	
Preferred Method of Contact:	SMS [ ] / Letter [ ] / Email [ ] Other [ ] *please note*: ……

I consent to the practice contacting me for the purposes of health promotion & for appointment reminders - I agree to advise the practice if my mobile number changes or if this is no longer in my possession.

Parents Signature:		Date:	

Ethnic Origin:	
Main Language:	

Next of Kin / Parents Details: *(Reception - please check against Birth Certificate)*	
Mothers Name:	
Mothers Date of Birth:	
Mothers Telephone:	
Fathers Name:	
Fathers Date of Birth:	
Fathers Telephone:	

Record Sharing:		
You have two choices which allow you to control how your record is shared. You can change these choices at any time by letting the relevant practice or service know.		
SHARING OUT	This controls whether your information recorded at this practice or service can be shared with other healthcare services.	YES / NO
SHARING IN	This determines whether or not this practice or service can view information in your record that has been entered by other services who are providing care for you, or who may provide care for you in the future.	YES / NO

Medication:	
If you take any medication regularly we will require you to see a GP before we can issue you any of these. Therefore please ensure you have enough medication to see you through from your previous surgery. The receptionist can assist you in booking this appointment. If you have previously nominated a pharmacy this will be removed from your record.	
How would you like to collect your prescriptions:	
I am a **Dispensing** patient *(Medications collected from surgery)*	Green paper prescription from the **Surgery** *(Green paper to take to any pharmacy)*
Electronic prescription sent to:	*(new nomination)*

Allergies:
Any allergies or reactions? (e.g. to: medications, medical dressings, vaccinations or foodstuffs):

Family History:		
Have any members of your family suffered from the following: *(if YES, please state which family member)*		
Heart Disease	YES / NO	
Stroke	YES / NO	
Diabetes	YES / NO	

Medical History:
Have you had any operations? Do you have any medical conditions?

Office Use Only:			
Birth Certificate seen by:			
Form checked by:		Date:	
Entered onto S1 by:		Date:	