

**NEW PATIENT REGISTRATION FORM (UNDER 18 YEARS)**

Whilst we are waiting for your child’s full medical records from their last doctor, it would help us if you could take the time to complete this questionnaire so that your child’s care is transferred as seamlessly as possible.

**Please bring in your child’s red book so we can take a photocopy of their immunisation record**

**Please remember to bring photo ID and proof of address for the registering adult**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Your child’s personal details** | | | | |
| Title | Miss Master Other | | | |
| Full Name |  | Date of Birth | |  |
| NHS Number |  | | | |
| Gender | □ Male □ Female | | | |
| Current Address |  | | Home telephone number |  |
| Mobile telephone number |  |
| Email address |  |

|  |  |  |  |
| --- | --- | --- | --- |
| 1. **Name of Parents/Guardians** | | | |
| Mother’s Name:  ………………………………….. | D.O.B. ………………………….. | Next of Kin  Yes / No | Legal responsibility  Yes / No |
| Father’s Name:  …………………………………… | D.O.B. ………………………….. | Next of Kin  Yes / No | Legal responsibility  Yes / No |
| Other legal guardian Name:  …………………………………… | D.O.B. ………………………….. | Next of Kin  Yes / No | Legal responsibility  Yes / No |

|  |
| --- |
| 1. **Previous details** |
| Previous GP (Name): |
| Previous GP Surgery (Name and Address): |
| Previous Health Visitor (if under 5 years old) (Name): |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. **Other family members at same address** | | | | |
| Name:  ………………………………….. | D.O.B. | * Male * Female | Relationship to child ………………………….. | Registered with Jenner House Surgery?  Yes / No |
| Name:  …………………………………… | D.O.B. | * Male * Female | Relationship to child ………………………….. | Registered with Jenner House Surgery?  Yes / No |
| Name:  …………………………………… | D.O.B. | * Male * Female | Relationship to child ………………………….. | Registered with Jenner House Surgery?  Yes / No |

|  |  |
| --- | --- |
| 1. **School details** | |
| Name of school/nursery/college attended: |  |
| Home educated? | Yes / No |

|  |  |
| --- | --- |
| 1. **Medical Information** | |
| **MEDICAL HISTORY** - Please give brief details of past and current problems. Any serious illness, operations, accidents, disabilities etc. Please include dates: | |
|  | |
| **ALLERGIES** – e.g. medications, animals, chemicals, foods etc. | |
| Any allergies? YES/NO | |
| If Yes Please give details: | |
| **FAMILY HISTORY** - Is there a family history of any of the following e.g. High Blood Pressure, Diabetes, Heart Disease, Stroke, or hereditary conditions? | |
| Please give details: | |
| **DRUGS/MEDICINES** – Please list all medications, taken whether prescribed or not: | |
|  | |
|  | |
|  | |
|  | |
|  | |
| Is your child registered with a dentist  *To find a dentist visit NHS Choices*  [*www.nhs.uk*](http://www.nhs.uk) | Yes / No |
| Is your child up to date with the following vaccinations, please tick   * Tetanus Date: * German measles Date: * Polio Date: * MMR Date: * Hib Date: * Diptheria Date: * Whooping cough Date: * Men B Date: * Men ACWY Date: * HPV Date: * Hep B Date:   *Please provide a copy of child’s vaccination record if available.* | |
|  | |
|  | |
|  | |

|  |  |
| --- | --- |
| 1. **ETHNICITY**   Choose ONE section A to E & tick the appropriate box to indicate your ethnic group. | |
| **A: WHITE**  □ British  □ Irish  □ Any other white background, please state………………………………………………………. | **B: MIXED**  □ White and black Caribbean  □ White and black Afrian  □ White and Asian  □ Any other mixed background, please state………………………………………………………. |
| **C: ASIAN OR ASIAN BRITISH**  □ Indian  □ Pakistani  □ Bangladeshi  □ Nepalese  □ Chinese  □ Any other Asian background, please state ……………………………………………………………. | **D: BLACK OR BLACK BRITISH**  □ Carribean  □ African  □ Any other Black background, please state ……………………………………………………………. |
| Please indicate first language here: | |
| Country of Birth: | |

1. **MAKING CARE ACCESSIBLE TO YOU**
2. Does your child find it difficult or needs support to see, to hear, to speak, to read or to understand what is being said? For example, if you are d/Deaf, blind, have hearing or visual loss or have a learning disability

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes always** |  | **Most of the time** |
|  | **No never** |  | **Not very often** |
|  | **Sometimes** |  | **Prefer not to say** |
| Please provide details of your condition (e.g. deaf, blind, hearing loss, visual loss or learning disability) | | | |

1. Does your child need help when you go to the doctors to communicate? For example, a British Sign Language interpreter or Language interpreter?

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes always** |  | **Most of the time** |
|  | **No never** |  | **Not very often** |
|  | **Sometimes** |  | **Prefer not to say** |
|  | **Does not need any communication support** |  |  |
| Please indicate here any communication needs you require (e.g. language interpreter, sign language interpreter: | | | |

1. Does your child need information from the doctors in a way you can understand? For example, easy read, braille, audio?

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Yes always** |  | **Most of the time** |
|  | **No never** |  | **Not very often** |
|  | **Sometimes** |  | **Prefer not to say** |
|  | **Does not need information in a special format** |  |  |
| Please indicate here how you would prefer to receive communications from the surgery: | | | |

|  |  |
| --- | --- |
| 1. **Required information** | |
| Is your child currently: | * A refugee * An asylum seeker * Homeless * None of the above |
| Is your child currently housebound:  Please provide details: | Yes / No |
| Is your child a looked after child under the care of the local authority? | Yes / No  If yes, in what capacity:  Which local authority:  Name of social worker: |
| Is your child or family currently involved with Childrens Services or the Safeguarding Team? | Yes / No  If yes, please give further details:  Name of social worker: |

|  |  |
| --- | --- |
| 1. **Carers identification** | |
| Is your child looking after someone at home? | *Please let us know if your child is looking after someone who is ill, frail, disabled, has mental health/emotional support needs, or substance misuse problems*  Yes / No  If so, who: |
| If yes to the above, would they like additional support as a young carer? | Yes / No |
| Is someone looking after your child at home? | Yes / No |
| Carers Name & Address:  Relationship to you:  Carer’s Telephone Number: |  |

|  |
| --- |
| **Communication Consent Form Declaration** |
| Jenner House Surgery may email you from time to time with practice information, health campaigns and eligibility for vaccines. We also send through our Practice Patient Newsletter.  Under the new rules of GDPR we are required to ask you for your permission to send you emails and texts.  I acknowledge that appointment reminders by text are an additional service and that they may not be sent on all occasions but that the responsibility for attending appointments or cancelling them still rests with me. I can cancel the text message facility at any time.  Text messages are generated using a secure facility but I understand that they are transmitted over a public network onto a personal mobile phone and as such may not be secure, however the practice will not transmit any information which would enable an individual patient to be identified.  Please note: if you change your mobile number and/or pass on your old mobile to another person, you will need to notify us so we can change our records. |
| **Text Messaging – please tick as appropriate** |
| * I do consent for Jenner House Surgery to send me text messages for the purposes of communicating practice information, health campaigns and eligibility for vaccines **(Admin – code 9Ndp)** * I do not consent for Jenner House Surgery to send me text messages for the purposes of communicating practice information, health campaigns and eligibility for vaccines |
| **Email Correspondence – please tick as appropriate** |
| * I do consent for Jenner House Surgery to send me emails for the purposes of communicating practice information, health campaigns and eligibility for vaccines **(Admin – code 9Nds)** * I do not consent for Jenner House Surgery to send me emails for the purposes of communicating practice information, health campaigns and eligibility for vaccines **(Admin – code 9Ndy)** |
| Signed: |
| Date: |

**Thank you for completing the above & welcome to Jenner House Surgery**