**New Patient Registration Form – Child (Up to the Age and including 15years)**

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  (Inc. postcode) |  | Date of Birth |  |
| Previous Address  (UK or International) |  | Mobile |  |
| Home Telephone |  |

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| **Parent or Guardian Details**  **\*Please use the space below to include more than 1 parent or guardian if required\*** | | | |
| Name |  | Relationship |  |
| Contact Number |  | | |
| Email | I consent to be contacted\* by email at this address: | | |

***\* It is your responsibility to keep us updated with any changes to your telephone number, email & address\****

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| **Other Details of Patient** | | | | | |
| Previous GP | Name: | | Surgery Address: |  | |
| Country of Birth |  | | | | |
| Ethnicity |  |  | |  |  |
| Religion |  |  | |  |  |

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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 | | |
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| Learning disability | Do you have a Learning Disability?  Yes  No  Mild  Moderate  Severe  Registered on the Learning Disability Register Yes  No | | |

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| **2. Medical History** |

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| **Medical History** |
| Do you have any medical conditions we should be aware of?  Please inform us of any operations or procedures you have had:  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 |
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| **Allergies** |
| Do you have any known allergies? Yes  No  If yes, please list below |

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| **Current Medication** |
| Do you take any prescription medication regularly? Yes  No  If yes, please list below.  **PLEASE BE ADVISED IF YOU TAKE REPEAT MEDICATION PLEASE BOOK A MEDICATION REVIEW BEFORE REQUESTING YOUR FIRST REPEAT PRESCRIPTION FROM US.** |

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| **Patient name: Date of Birth:** | | |
| If your child has had any of the following vaccinations, please enter the dates (DD/MM/YYYY) if known and also the country where given or bring in a copy of your child’s vaccination record.  *(Please be aware that the UK vaccination programme may be different to that of other countries)* | | |
| ***Vaccination:*** | ***Date:*** | ***Place:*** |
| 1st Diphtheria/Tetanus/Whooping cough (Pertussis)/Polio/Hib |  |  |
| 2nd Diphtheria/Tetanus/Whooping cough (Pertussis)/Polio/Hib |  |  |
| 3rd Diphtheria/Tetanus/Whooping cough (Pertussis)/Polio/Hib |  |  |
| 1st Rotavirus |  |  |
| 2nd Rotavirus |  |  |
| 1st Pneumococcal |  |  |
| 2nd Pneumococcal |  |  |
| 3rd Pneumococcal |  |  |
| 1st Meningitis C |  |  |
| 2nd Meningitis C |  |  |
| 1st Meningitis B |  |  |
| 2nd Meningitis B |  |  |
| Booster Meningitis B |  |  |
| Hib booster or Hib/Men C booster |  |  |
| 1st Measles/Mumps/Rubella |  |  |
| 2nd Measles/Mumps/Rubella |  |  |
| 4th Diphtheria |  |  |
| 4th Tetanus |  |  |
| 4th Whooping cough (Pertussis) |  |  |
| 4th Polio |  |  |
| 4th Hib (optional) |  |  |
| 1st Hepatitis A |  |  |
| 2nd Hepatitis A |  |  |
| 1st Hepatitis B |  |  |
| 2nd Hepatitis B |  |  |
| 3rd Hepatitis B |  |  |

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| **3. Further Details** |

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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 |  |

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| **Electronic Prescribing** | |
| All prescriptions go electronically to a pharmacy of your choice. Please nominate a pharmacy. | Name of Pharmacy: |

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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 |  |

**Practice Use Only**

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| Appointment | Required | Not Required |  |  |
| ID Seen | Passport | Identity card | Other : |  |
| Checked By | Sign | Date |  |  |
| Entered on S1 by | Sign | Date |  |  |