**Dukinfield Medical Practice**

Dr J Harvey, Dr E Roberts, Dr H McBride, Mr B Parsons, Mrs J Pregnall, Dr R WIlliams

# *New Patient Registration Form (Child 12 years and under)*

**Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).**

**Please complete in BLOCK CAPITALS and tick the boxes as appropriate.**

**For a child to be registered with the practice, a parent, guardian, or care giver (looked after child) must also be registered with the practice.**

***Please bring identification (red book, birth certificate or passport)***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Full Name:** | | | | **NHS Number:** |
|  | **Male** |  | **Female** | **Daytime Telephone Number:**  **Mobile Number:** |
| **Date Of Birth:** | | | |
| **Current address and postcode** | | | | |
| **E-mail Address:** | | | | |
| **Previous address :** | | | | **Town & Country of Birth:** |
| **If born outside the UK, date you entered the country:** |
| **Previous GP (surgery name and address)** | | | | |

**All patients will now be allocated to Dr McBride as their named accountable GP.**

**Please note that you can see any GP within the practice.**

# Family details – the following section must be completed in order for the practice to register a child.

|  |  |  |
| --- | --- | --- |
| **Name of First Parent/Guardian/**  **Care giver (Looked after child)**  **Date of Birth** | | **Name of Second Parent/Guardian/**  **Care giver (Looked after child)**  **Date of Birth** |
| **Telephone number**  **Home:**  **Mobile:** | | **Telephone number**  **Home:**  **Mobile:** |
| **Address details (if different from child)** | | **Address details (if different from child)** |
| **Who has parental responsibility? (please tick all that apply)**   |  |  | | --- | --- | |  | **Mother** | |  | **Father** | |  | **Someone else (please state the name and their relationship to the child)** | | | |
| **Next of kin emergency contact( if different from above)** | | |
| **Name & Address:**  **Relationship to the child:** | **Telephone (home)** | |
| **Telephone (work)** | |
| **Telephone (mobile)** | |

**What is the child’s main or first spoken language? (One predominantly spoken at home)**

|  |  |  |  |
| --- | --- | --- | --- |
| **YES** |  | **NO** |  |

**Does this child require an interpreter? (Please note that it is the practice safeguarding policy that an independent interpreter service is used for all patients who do not speak English in consultations).**

**What is their ethnicity?**

|  |  |  |
| --- | --- | --- |
| **White** | **White British** |  |
| **Other white** |  |
| **Mixed/Multiple Ethnic groups** | **White and Black Caribbean** |  |
| **White and Black African** |  |
| **White and Asian** |  |
| **Any other Mixed/Multiple ethnic background** |  |
| **Asian/Asian British** | **Indian** |  |
| **Pakistani** |  |
| **Bangladeshi** |  |
| **Chinese** |  |
| **Any other Asian background** |  |
| **Black/ African/ Caribbean/ Black British** | **Black African** |  |
| **Black Caribbean** |  |
| **Any other Black background (black/ African/ Caribbean background)** |  |
| **Other ethnic group** |  |  |

# *Relevant medical history*

|  |  |  |
| --- | --- | --- |
| **Is your child on any medication at present? If so please specify** | | |
| **Is your child allergic to anything? If yes what reaction did your child have and when?** | | |
| **Has your child had any operations or serious illness?** | | |
| **Family History- has any member of your child’s close family (parents, brothers, sisters, grandparents, aunts, uncles) had any of the following illnesses? (please tick if applicable and provide details)**  **Tick below Family Member details** | | |
|  | **Heart disease (over 60 years of age)** |  |
|  | **Heart disease (under 60 years of age)** |  |
|  | **High blood pressure** |  |
|  | **Stroke** |  |
|  | **Diabetes** |  |
|  | **Asthma** |  |
|  | **Cancer** |  |
|  | **Depression/ Mental Health illness** |  |
|  | **Any other important family illness** |  |

# *Other information*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Is your child home-schooled? | | YES |  | NO |  |
| Name of Child’s Current School | Name of previous schools (if any) | | | | |
| Name of Health Visitor/ School Nurse (if known) |  | | | | |
| Is this child (or have they ever have been) subject of a Child Protection Plan? | YES / NO | | | | |
| If yes, please provide more details: | | | | | |
| Is this child (or ever has been) a “Looked After” child (in Foster Care or in a Children’s Home?) | YES / NO | | | | |
| If yes, please provide more details: | | | | | |
| Has your child ever been allocated a social worker or FNP? | YES / NO | | | | |
| If yes, please provide more details including dates & name of social worker if known | | | | | |

|  |  |
| --- | --- |
| Please detail any special need’s your child may have so the Practice can ensure they are identified and accommodated by taking the appropriate action. Please state below. | |
| Please state any sensory impairment your child has i.e. visual, hearing, sight |  |
| Please state any physical disabilities your child has |  |
| Please state any mental disabilities your child has |  |
| Please state any requirements your child has to be able to access the surgery |  |
| Please state any religious or cultural needs |  |
| Please state any specific nutritional requirements your child may have |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **What immunisations has the child received**  **(please tick all that apply)** | **Measles** | **German**  **Measles** | **Diphtheria** | **Tetanus** | **Polio** | **MMR** |
| **Whooping Cough** | **Pre-school booster** | | **Triple vaccine (Diphtheria,**  **Tetanus & Pertussis) –**  **3 doses** | | |

# *Details of a child’s immunisation history should be available from the red immunisation record book.*

# *Summary care records*

The NHS is changing the way your health information is stored and managed. The NHS summary care record is an electronic record of important information about your health. It is available to health care staff providing your NHS care. Please ask at reception for more information.

|  |  |  |
| --- | --- | --- |
| Are you happy to have a summary care record? | Yes | No |

|  |  |
| --- | --- |
| The practice wishes to expand its methods of communicating with patients to include the use of email and text messaging.  Patient privacy is important to us, and we would like to communicate with you regarding any activities that may be of interest, which means that we need your consent. This may include using text/emails to provide updates on new developments at the practice, quarterly newsletters, and invitations to community health events.  Emails and text messages are generated using a secure facility, but because they are transmitted over a public network they may not be secure. Email and text communication will never be used for urgent communications. Your contact details will be used solely in relation to healthcare services offered by the practice, and you can choose to opt out of the services at any time by contacting the practice. | |
| If you wish to receive emails please sign here |  |
| If you wish to receive text messages please sign here (please note that this does not relate to appointment confirmation and reminders) |  |

Office use only

Proof of ID……………………………………………………………………………………………

Staff name and signature…………………………………………….. ………………………………………………………

Date………………………………………………………………………….

Date registered………………………………………………………………

When registering your child, please supply at least ONE of the following

* Passport
* Birth certificate
* Red Immunisation book

**Proxy User - Online Access registration forms**

**If applicable is third party consent already in place: YES / NO**

For access to the record belonging to:

Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Proxy User Details:

Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to user:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you already have a Patient access account:  **YES / NO**

Are you a patient at Dukinfield Medical Practice:  **YES / NO**

**If you are not currently a patient at Dukinfield Medical Practice please fill out the following:-**

Current address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact telephone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please note: separate consent forms for other family members will be required

**For office use only:**

**ID:**

**Received by:**

**Date received:**