The Argyle Surgery

New Patient Registration Questionnaire (Under 16s)

Welcome to our surgery! Thank you for taking the time to complete this questionnaire in BLOCK CAPITALS

PERSONAL DETAILS	
Name:	Gender: ☐ Male ☐ Female
Address: Postcode:	Date of Birth: / /
Home Tel:	Mobile: We will use this to send appointment reminders and health promotion details. Please tick here if you do not want to receive messages from us: ☐
Main Language (if not English):	NHS No (if known): Does your child need an interpreter? ☐ Yes ☐ No
Town of Birth:	Country of Birth:
Does your child need help with mobility/hearing/ speaking? (tick all that apply) ☐ Wheelchair ☐ Walking aid ☐ Hearing aid ☐ British Sign Language ☐ Makaton sign language ☐ Lip reading ☐ Large print ☐ Braille ☐ Other Please state:	
Is your child currently ☐ Homeless ☐ A refugee ☐ An asylum seeker	

YOUR CHILD'S ETHNIC ORIGIN	Please tick one box only (national 2011 census categories)			
White	**Mixed/Multiple Ethnic**	**Asian / Asian British**	**Black/African/Caribbean/ Black British**	**Other Ethnic Group**
☐ English/Welsh/Scottish /Northern Irish /British	☐ White and Black Caribbean	☐ Indian	☐ African	☐ Arab
☐ Irish	☐ White and Black African	☐ Pakistani ☐ Bangladeshi	☐ Caribbean	☐ Other Ethnic (specify) .....
☐ Gypsy or Irish Traveller	☐ White and Asian	☐ Chinese	☐ Other Black (specify)	☐ I do not wish to answer this question
☐ Other White (specify)	☐ Other Mixed (specify)	☐ Other Asian (specify)		

Please state all countries you have lived in or visited for periods of greater than 6 months:	
Country:	Dates/Year if known

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NEXT OF KIN	Name: Tel: Relationship:

Please list other relatives of your home who are registered with us		
Relationship:	Name:	Date of Birth:

Looking after someone

Is your child looking after someone? ☐ Yes ☐ No

Let us know if your child is looking after someone who is ill, frail, disabled or has mental health and/or emotional support needs, or substance misuse problems.

Is someone looking after your child? ☐ Yes ☐ No

Let us know if a family member, friend or neighbour looks after your child.

Carer's name: Relationship to you:

Address of carer:

Telephone number of carer:

MEDICAL HISTORY	
Does your child have any chronic conditions? If yes, please give details:	Date of diagnosis:
What operations has your child had?	Date of operations:
Please list any tablets or medications that your child is currently taking:	

FAMILY HISTORY	Please state if any family member has suffered from any of the following conditions: Asthma, COPD, Epilepsy, Stroke, Diabetes, High Blood Pressure, High Cholesterol, Heart Disease, Mental Illness, Thyroid Disorder, Cancer or other (please specify)				
Illness/Condition	1.	2.	3.	4.	5.
Family member					
Aged diagnosed					

Vaccinations	Which vaccinations has your child had?				
Age	**Immunisation**	**Date (DD/MM/YY)**	**GP Surgery**	**Private**	**Abroad**
2 months	1st Diphtheria, Tetanus, Pertussis		☐	☐	☐
	1st Polio		☐	☐	☐
	1st HIB		☐	☐	☐
	1st Pneumococcal Vaccine		☐	☐	☐
	1st Rotavirus		☐	☐	☐
	1st Meningitis B		☐	☐	☐
3 months	2nd Diphtheria, Tetanus, Pertussis		☐	☐	☐
	2nd Polio		☐	☐	☐
	2nd HIB		☐	☐	☐
	1st Meningitis C		☐	☐	☐
	2nd Rotavirus		☐	☐	☐
4 months	3rd Diphtheria, Tetanus, Pertussis		☐	☐	☐
	3rd Polio		☐	☐	☐
	3rd HIB		☐	☐	☐

	2nd Pneumococcal Vaccine		☐	☐	☐
	2nd Meningitis B		☐	☐	☐
12 months	Hib/Men C Booster		☐	☐	☐
	3rd Meningitis B		☐	☐	☐
13 months	MMR (Measles, Mumps, Rubella)		☐	☐	☐
	3rd Pneumococcal Vaccine		☐	☐	☐
3½ to 5 Years	MMR Booster (Measles, Mumps, Rubella)		☐	☐	☐
	Pre-School Booster Diphtheria, Tetanus, Pertussis & Polio		☐	☐	☐
13-18 Years	Booster Diphtheria, Tetanus & Polio		☐	☐	☐
	1st Meningitis A		☐	☐	☐
	Meningitis C		☐	☐	☐
	1st Meningitis W		☐	☐	☐
	1st Meningitis Y		☐	☐	☐

Sharing your child's Medical Record

Medical Record Sharing allows your complete child's complete GP medical record to be made available to authorised healthcare professionals involved in your child's care. You will always be asked your permission before anybody looks at your child's shared medical record.

If you don't want to share your child's GP record tick here: ☐

Summary Care Record contains details of your child's key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. You will always be asked your permission before anybody looks at your child's Summary Care Record.

If you don't want your child to have a Summary Care Record tick here: ☐

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The Care.data Programme Collates information about your child and the care they receive. It links information from all the different places where your child receives care, such as your GP, hospital and community services, to help them provide a full picture of your child's medical needs and the care your child is receiving. This data is made available to NHS Commissioners so that they can design integrated services and is shared with third parties for research purposes.

☐ **I wish to OPT OUT from my child's Personal Confidential Data being shared outside my *GP practice*:**

☐ **I wish to OPT OUT from my child's Personal Confidential Data being shared with *third parties*:**

Online Services

You can now do the following online or via the SystmOnline app:

- Book and cancel appointments, order repeat prescriptions,
- view your Detailed Medical Record (by application)

IT WILL BE YOUR RESPONSIBILITY TO KEEP YOUR LOGIN DETAILS AND PASSWORD SAFE AND SECURE. IF YOU KNOW OR SUSPECT THAT YOUR RECORD HAS BEEN ACCESSED BY SOMEONE THAT YOU HAVE NOT AGREED SHOULD SEE IT, THEN YOU SHOULD CHANGE YOUR PASSWORD IMMEDIATELY.

Parents can apply for online access to their child's record if the practice can verify the parental relationship. Online access for parents is disabled at age 11 and the child will need to apply for their own online access.

☐ ***Yes*** I'd like to register for online services for my child	☐ ***No*** I don't want to register for online services for my child

Required information

Name of parent/s	**1.** **2.**
Name of person with legal parental responsibility	
Name of school attended:	
Personal Details (Name, address and date of birth) are shared with the local health visiting team for all children under the age of 5.	

Signature

Parent/Guardian signature	

CHECKLIST	
Thank you for completing this form. Please check you have completed all sections where possible. Please ensure that you bring the following with you to the surgery to complete your registration:	
1. Completed & Signed New Patient Registration Questionnaire (this form!)	☐
2. Completed & Signed GMS1 Form	☐
3. Photo Proof of ID - e.g. Passport, Photo Driving License or Photo ID card	☐
4. Proof of Address – Must be in your name and dated within the past 3 months – One of the following: Bank statement, Utility Bill (Gas, Electricity, Water), Council Tax, Tenancy Agreement or Landline Phone Bill (Mobile phone bills are not accepted)	☐
5. If possible, your **Immunisation Records** – usually the Personal Child Health Record ("Red Book")	☐
6. If possible, your **NHS Card** – usually shows your previous GP and your NHS Number	☐
7. If relevant, your **Repeat Medication Request Slip** from your previous GP	☐

Please book a New Patient appointment if you are on any regular medication or have any chronic or significant medical condition.

Please request a copy of the Practice Leaflet if you have not already received it. Alternatively you can also find more information at our practice website http://www.argylesurgery.nhs.uk

I confirm that I have completed this form as accurately and honestly as possible and would like to apply to be registered as a patient at this practice

Signature: **Date: / /20**

OFFICE USE ONLY	Need Appt? ☐ Yes ☐ No TB screening? ☐ Yes ☐ No			**Staff Initials:**
Photo ID	☐ Passport	☐ Driving licence	☐ Identity card	☐ Other
Proof of Address	☐ Utility Bill	☐ Tenancy Agreement	☐ Bank Statement	☐ Other

<Organisation Address>

<Organisation Details>