**NEW CHILD PATIENT REGISTRATION**

Please complete this form as clearly as possible and return to us along with a form ID if possible

**ABOUT YOU / YOUR CHILD** NHS number (if known) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male 🞏 Female 🞏

Title Master 🞏 MR 🞏 Miss 🞏 Other\_\_\_\_\_\_\_\_\_\_\_\_ First Name(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Surname *(if applicable)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_ /\_\_\_\_\_\_\_ /\_\_\_\_\_\_\_\_ Town & Country of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Post Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous address in the UK \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and address of Previous Doctors Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where did your child last receive treatment? E.g. *GP, Walk in Centre, MIU, Emergency Department etc*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Date of visit:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Landline number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Preferred Mobile number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞏 Preferred

Email Icon Png, Transparent Png - kindpng

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate your ethnic origin:

🞏 White – British 🞏 White – Irish 🞏 White - Gypsy or Irish Traveller 🞏 White – Other 🞏 African 🞏 Caribbean 🞏 Indian 🞏 Pakistani 🞏 Bangladeshi

🞏 Chinese 🞏 Black or Black British -Other 🞏 Arabian 🞏 White and Asian

🞏 White and Black African 🞏 White and Black Caribbean 🞏Mixed – Other 🞏 Other

🞏 Decline to state

**If you are from abroad:**

Your first UK address where registered with a GP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If previously resident in UK date of leaving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date you first came to UK: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NEXT OF KIN DETAILS TO BE HELD ON YOUR CHILD’S FILE:**

Their name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I confirm that the information I have provided is true to the best of my knowledge

**If you need your GP to dispense prescriptions:**

🞏 Tick here if you live more than 1 mile in a straight line from the nearest pharmacy and we will dispense your medication at the surgery. Otherwise please tell us where you would like to collect your medication from.

Name of pharmacy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Town \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CARER INFORMATION**

Are you a young carer? YES 🞏 NO 🞏   
*If yes, do you consent to this information being held on our Carer’s Register?* YES 🞏 NO 🞏

**FAMILY HISTORY**

Please indicate in the boxes if any close relatives (father, mother, sister, brother only) have ever suffered from the following: -

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| HEART ATTACK | STROKE | DIABETES | HIGH BLOOD PRESSURE | ASTHMA | GLAUCOMA | CANCER |
|  |  |  |  |  |  |  |

**Please list any allergies you have to any drugs / medication**

**Name of medication What was the problem or upset**

**Immunisations**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Immunisation | Year | Immunisation | Year | Immunisation | Year |
| Tetanus |  | Polio |  | Whooping cough |  |
| Typhoid |  | Yellow Fever |  | MMR |  |
| Hepatitis A |  | HiB |  | Meningitis |  |
| Measles |  | Booster: Tetanus |  | Booster: MMR |  |
| BCG (TB) |  | Booster: Diphtheria |  | Booster: Polio |  |

**Personal Medical History**

Type of birth (eg.normal, forceps, caesarean if under 5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth weigh (if under 5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Feeding if under 5 : Breast/ Bottle/Both

Has your child ever had any important medical illness, operation or admission to hospital? If so please enter details below:

Condition Year diagnosed Ongoing

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes / No

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes / No

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes / No

|  |  |
| --- | --- |
| **List of current medication - if you have a copy of repeat medication, please pass to reception to copy** | |
| **Name of Medication** | **Dosage** |
| **1.** |  |
| **2.** |  |
| **3.** |  |

|  |  |
| --- | --- |
| **Please list any allergies your child has to any drugs/medication/substances eg. Latex** | |
| **Name of medication** | **What was the problem or upset** |
| **1.** |  |
| **2.** |  |
| **3.** |  |

**HEALTH RECORD CONSENT**

|  |  |
| --- | --- |
| Do you consent to your GP Practice viewing your health record from other services that care for you?  Yes 🞏 (recommended) No, never 🞏 | Do you consent to your GP health record being made available to other NHS care services that care for you?  Yes 🞏 (recommended) No, never 🞏 |

**SUMMARY CARE RECORD** [**https://digital.nhs.uk/services/summary-care-records-scr**](https://digital.nhs.uk/services/summary-care-records-scr)

Having read the above information in the above link regarding your choices, please choose one of the options below:

🞏 Express consent for medication, allergies, adverse reactions and additional information (**recommended**)

🞏 Express consent for medication, allergies and adverse reactions only.

🞏 Express dissent for Summary Care Record (OPT OUT)

Patient signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COMMUNICATION**

Where you are providing information and ticking consent boxes, you are agreeing to The Orchard Partnership contacting you by text message, email, or voicemail for the purpose of appointment reminders, results, action needed following test results, referrals, health promotions, non-NHS work, medication, and Partnership updates.

Please be aware that the responsibility for attending appointments and cancelling them, as well as contacting the Partnership to obtain the results of recent tests, still rests with the patient, or parent / guardian.

**Consent to receive communication**The parents/guardians of children aged 11 or under may use these services e.g. to be reminded of children’s appointments. However, on the child’s 12th birthday, this service will be removed until the child turns 16 and personally completes a consent form.

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Description automatically generatedEmail Icon Png, Transparent Png - kindpngBy Email 🞏 Yes 🞏 No By Text 🞏 Yes 🞏 No By Voicemail 🞏 Yes 🞏 No

**My preferred communication method is:**

Email Icon Png, Transparent Png - kindpng By Email 🞏 Yes 🞏 No By Text 🞏 Yes 🞏 No  Letter 🞏 Yes 🞏 No

*If you have additional needs, please tell us which way you would prefer us to communicate with you (you may choose multiple)*

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**Details:** Your name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your date of birth: \_\_\_\_\_\_\_\_\_\_Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_  
Mobile number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Who’s number is this: 🖵 Mother 🖵 Father 🖵 Legal guardian

Landline: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who’s email is this: 🖵 Mother 🖵 Father 🖵 Legal guardian

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_