Woodbury Surgery

BABY AND YOUNG CHILDREN

CONFIDENTIAL MEDICAL REGISTRATION FORM – NEW PATIENTS

PATIENT DETAILS Please complete in full using BLOCK capitals and circle where appropriate

Does the patient have communication needs that we need to be aware of?																								YES		NO
Mr / Miss other:	Surname:																									
Male / Female	First name/s:																									
NHS No: (if known)												Date of Birth:														
Home Address:																										
Postcode:																										
Mobile phone number:																										
Home phone number:												Preferred contact method (please circle)														
												Email						SMS							Letter	
Email Address - (please enter each character / symbol in separate box)																										
Where you have provided us with a mobile number and/or email address we may use these methods to contact you regarding the patients' healthcare e.g. appointment reminders, health checks due, health promotion and practice news.																										

CARERS: a carer is someone who, without payment, provides help and support to a child, relative, friend or neighbour, who could not manage without their help. This could be due to being elderly, physical or mental illness, addiction or disability.

Do you have a carer?	Yes	No			
Is the person that provides care for you registered at Woodbury Surgery?	Yes	No			

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FAMILY HEALTH HISTORY

Please tick if the patients parents, brother(s) or sister(s) suffer(ed) from any of the problems listed below:

Please tick and then **circle which family member**

Diabetes		Father / Mother / Sister / Brother
Asthma		Father / Mother / Sister / Brother
High Blood Pressure		Father / Mother / Sister / Brother
Stroke		Father / Mother / Sister / Brother
Heart Disease		Father / Mother / Sister / Brother
Cancer		Father / Mother / Sister / Brother

PATIENT OWN HEALTH: Please list if the patient has important illnesses or disabilities we need to be aware of:

IMMUNISATIONS (IF APPLICABLE)

Immunisation	**Year**	**Immunisation**	**Year**
Tetanus		Polio	
Typhoid		Yellow Fever	
Hepatitis A		Hepatitis B	

ALLERGIES

Name of medication	**What was the problem or upset?**		
Please indicate if you have an allergy to:	Peanuts	Eggs	Latex

MEDICATION

Is the patient taking any regular / repeat medication? If so please attach the most recent repeat prescription list from your previous GP surgery, or list below this information is essential to enable your new GP to authorise future repeat medication.		

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NEXT OF KIN

Title/Name:					
Address:					
Mobile		Landline		Relationship to patient	

Title/Name:					
Address:					
Mobile		Landline		Relationship to patient	

PATIENTS ETHNICITY AND LANGUAGE

The NHS requires all medical records to show patients ethnic origin together with native or first language. Please tick the appropriate box:

WHITE: British or Mixed British		ASIAN: Pakistani or British Pakistani	
WHITE: Irish		ASIAN: Bangladeshi or British Bangladeshi	
WHITE: Any other background		ASIAN: Any other background	
MIXED: White and Black Caribbean		BLACK: Caribbean	
MIXED: White and Black African		BLACK: African	
MIXED: White and Asian		BLACK: Any other background	
MIXED: Any other background		CHINESE:	
ASIAN: Indian or British Indian		ANY OTHER ethnic group	
What is the patients first spoken language?		I prefer not to specify patients ethnic group.	
Does the patient require a translator? (Xal8X)	YES NO (please circle)		

We will record the patients first spoken language as ENGLISH unless you specify otherwise.

CONSENT

This information will be stored on a confidential clinical database. It is your choice which of this information is shared with other NHS services. Please read the enclosed '**SHARING YOUR NHS PATIENT DATA'** and complete and sign the form '**NHS PATIENT INFORMATION SHARING – MY CHOICES'.** If you have provided us with a mobile number and/ or an email address it is your responsibility to inform us immediately of any change to this information and to maintain the security of your phone/ computer. **Please note by signing this form you are consenting to receiving texts and emails from the practice regarding your health care.**	
SIGNATURE ON BEHALF OF PATIENT:	
DATE:	