Grafton Road Surgery

New Patient Registration – UNDER 16 YEARS

Your Details

Please complete and return this questionnaire together with **2** forms of identification.

- Passport or photo driving licence or National Identity Card.
- Bank/Building Society statement or utility bill (less than 3 months old) showing home address.

Have you been registered with this surgery in the past? Yes ☐ No ☐

If yes, when? ……..

Your Nominated/Allocated GP is your Registered GP

NHS Number **(Available from Previous Surgery)**	
Title **(Mr, Mrs, Mis, Miss etc)**	
Surname	
First Name	
Date of Birth	
Address Line 1	
Address Line 2	
Address Line 3	
Post Code	
Email Address	
Home Telephone No.	
Mobile Telephone No.	

Previous Details

Please help us trace your previous medical records by providing the following information:

Previous Doctor	
Previous Surgery Name	
Address	

Your Previous Address

Address Line 1	
Address Line 2	
Address Line 3	
Post Code	

If you were not born in England

Place of Birth	
Date you arrived in UK	

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Ethnicity
(Please circle as appropriate)

White	Mixed	Black	Asian	Chinese
White British White Irish White European	White / Black Caribbean White / Black African White / Asian	Black British Black Caribbean Black African Other Black background	Indian Pakistani Bangladeshi Other Asian Background	
	Any other ethnic category ; please state			

Main Language Spoken	

Next of Kin

Name	
Relationship	
HomeTelephone No	

Next of Kin (Emergency Contact – if different from above)

Name	
Relationship	
Home Telephone No	
Mobile Telephone No	

Family Details

Mother's Name	
Home Telephone No	
Mobile Telephone No	
Address If different to child	

Fathers's Name	
Home Telephone No	
Mobile Telephone No	
Address If different to child	

Who has parental responsibility? (Please circle one or both if applicable) MOTHER / FATHER

Other (please state name and relationship to child) _____

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Please list all of the people (children & adults) that share the same household and their relationship to the child

Name of Person	Adult or Child (Under 18)	Relationship to Child	Are they registered at this practice
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No
			Yes / No

Further Information

Is your Child Home Schooled?	**Yes / No**
Name of Child's Current School	
Name of Previous School (if any)	
Name of Health Visitor / School Nurse	
Has your Child ever been allocated a Social Worker or other Professional ?	**Yes / No**
If YES when ?	
Has your child ever been the subject of a Child Protection Plan?	**Yes / No**
Has your child every been a "Looked After Child" i.e in foster care or a children's home	**Yes / No**
If Yes when?	

Details of routine childhood vaccinations (You may wish to supply a copy of their red book personal child health record)

Vaccine	Date Given	Date Given	Date Given
Diptheria			
Tetanus			
Polio			
Whooping Cough			
Hib			
Hep B			
Pneumococcal			
Rotavirus			
Men B			
MMR			

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Family History

Has any close family member (grandparent, parent, brother, sister, aunt or uncle) had any of, or suffer from, any of the following?

Problem	Their Relationship To You	Their Age when Diagnosed
Heart Attack		
Angina		
Stroke		
Asthma		
Diabetes		
Cancer **(State type, eg. bowel, breast)**		

Alcohol Habits

One alcohol unit equals one 25ml single measure of whisky (ABV 40%), or a third of a pint of beer (ABV 5-6%) or half a standard (175ml) glass of red wine (ABV 12%).

Please complete the following by circling the appropriate answer:

Do you drink alcohol?	**Yes / No**

Estimated Units Per Week	

How often do you have 8 (Men) 6 (Women) or more drinks on one occasion?

Never	Less than Monthly	Monthly	Weekly	Daily	Almost Daily

How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never	Less than Monthly	Monthly	Weekly	Daily	Almost Daily

How often during the last year have you failed to do what was normally expected of you because of drinking?

Never	Less than Monthly	Monthly	Weekly	Daily	Almost Daily

In the last year has a relative or friend, or doctor or other health worker been concerned about your drinking or suggested that you cut down?

No	Yes	At least one occasion

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Current Medication

Please give details of any medication which you take (prescribed or otherwise):

Name of Drug	Dosage

Would you like to nominate a Pharmacy for prescriptions? **If Yes all future prescriptions will be sent electronically to your nominated pharmacy**	**Yes / No**
Pharmacy Name and address:	

Past Medical History

Please give details of any previous significant past medical history :

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Carers

Do you have a Carer? Yes / No

If YES please provide their details :

Name	
Address	
Telephone No	

Are you a Carer ?

Do you look after someone who is ill, frail, disabled or mentally ill?

Name	
Address	
Telephone No	

Data Sharing

You need to let us know if you wish to opt out of any of the services below :

Summary Care Record

A Summary Care Record is an electronic record which contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you have had.

Having this information stored in one place makes it easier for other healthcare staff to treat you in an emergency, or when your GP Practice is closed.

YES - **I DO** wish to have my Summary Care shared with other Healthcare Professionals	
NO - **I DO NOT** want my Summary Care Record shared with other Healthcare Professionals	

Signature of Patient	

Name and Signature on Behalf of Patient	

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Your Care Connected

This is a more detailed record that can be shared with local hospitals and community services throughout Solihull, Birmingham and Sandwell. This enables all organisations to share important details of your medical history along with investigations, test results, medication etc.

The aim is to improve communication across local GP's, hospitals and community services and helps avoid duplicating investigations such as blood tests.

I wish to OPT OUT of Your Care Connected	

Signature of Patient	

Name and Signature on Behalf of Patient	

Consent for Communications

	YES / NO	Date
I consent to receiving Text messages for appointments, reminders etc		
I consent to receiving Email Messages for appointments, reminders etc		

Accessibility

We aim to ensure that all patients have access to services at the Practice. If you require accessibility support please detail below;

British Sign Language Interpreter	☐
Audible Alerts	☐
Large Print	☐
Accessing Test Results, Immunisations and Problems	☐

What is your preferred method of communication?	
How would you like us to communicate with you?	
What support would be helpful?	
What is the best way to send you information?	

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Access to GP Online Services Form

In order for Access to be given Identity **must** be verified, please provide one of the following for verification:

- Passport
- Photo Driving Licence
- National Identity Card

Surname	
First name	
Date of birth	
Address	
Postcode	
Email address	

I wish to have access to the following online services (tick all that apply):

Booking appointments	☐
Requesting repeat prescriptions	☐
Accessing Test Results, Immunisations and Problems	☐

For practice use only

Identity Verified By: (Please Tick)	Vouching		Photo ID	

Verified By	Name:	Signature:	Date

Scanned to Record By:	
Date scanned:	
Use Read Code	Xabui