New Patient Registration Questionnaire

Children up to 15 years old

Please write in BLOCK CAPITALS.

Full Name (including middle):	Date of Birth:
Please state your child's birth gender? ☐ Male ☐ Female Is your child's gender identity the same as the sex they were assigned at birth? ☐ Yes ☐ No ☐ Prefer not to say	Mother's Full Name: Mother's Date of Birth: Father's Full Name: Father's Date of Birth:

NEXT OF KIN

Name:	Contact Tel No:	Relationship to Patient:

Does your child have a Carer? ☐ Yes ☐ No *If yes, please give carer's details*

Name: Contact Details:

CONTACT DETAILS

Email:	Mobile:
Wherever possible we prefer to send out information via email, this will include your new patient registration information and your Patient Access PIN document, should you choose to sign up to the service. Are you happy to receive emails from us? ☐ Yes ☐ No	We offer an appointment reminder SMS messaging system. This will also include general health information and Practice information such as changes to opening times, simple health status questions and recalling patients for chronic disease management. Are you happy to receive SMS messages from us? ☐ Yes ☐ No

Please state your preferred method of contact:
☐ Email ☐ SMS (text) ☐ Mobile Tele. ☐ Home Tele (please state)…….

ONLINE SERVICES

Patient Access (Proxy User)

We offer online services to all patients, this can be accessed via Patient Access or the NHS app. This allows you to;

- Order repeat prescriptions
- Change your contact details
- View your full medical record (from date of registration onwards)

You can sign your child up for this service dependant on their age;

- Aged 0-11 years – parent/guardian can have full access if required
- Age 11 – 15 years – parent/guardian can only have access to medications and basic summary

If you wish to subscribe to this service, please complete the Proxy Access form on page 6.

PREVIOUS DETAILS

So we can ensure that we have your child's full medical record, please provide us with any previous names your child may have held, your child's last three addresses in the UK and your child's last three GP surgery addresses (if applicable).

It is vital that we have your child's full medical record, this is important so we can maintain screening programmes, provide your child with the best care and keep your child's medical records complete.

Primary Care Service England (PCSE) will pause your child's registration with the practice if they find a possible match to your child's demographics on the NHS Spine, therefore providing us with this information now can prevent this from happening.

PREVIOUS NAME(S):

PREVIOUS ADDRESS(ES):

PREVIOUS GP PRACTICE(S):

PUBLIC HEALTH STATISTICS

Your Child's Religion

☐ Buddhist ☐ Catholic ☐ Christian
☐ Hindu ☐ Jehovah's Witness ☐ Jewish
☐ Muslim ☐ No religion ☐ Other:

Your Child's Ethnic Origin

☐ White British ☐ White Irish ☐ White Other ☐ Black Caribbean / British
☐ Black African / British ☐ Other Black Background ☐ Indian / British Indian ☐ Pakistani / British
☐ Arabic ☐ Bangladeshi / British ☐ Chinese ☐ Other Asian Background
☐ Other Mixed Background ☐ Other, please state: ☐ Ethnic Category Refused

What is your child's main spoken language?
Please state below;

Does your child speak English? ☐ Yes ☐ No

Do you or your child use an Interpreting app on your phone?
☐ **Yes** ☐ **No**

Does your child require an Interpreter present at appointments?
☐ Yes ☐ No

HEALTH INFORMATION		
Weight:	**Height:**	**How much exercise does your child do?** ☐ None ☐ Light ☐ Moderate ☐ Vigorous

YOUR CHILD'S MEDICAL BACKGROUND

Does your child have any disabilities?

Does your child have any drug or food allergies? Please list:

Does your child have any major health issues you wish the doctor to be aware of? Please list:

REPEAT MEDICATIONS

Is your child taking any regular medications? If so please give details in the box below;
If your child is taking more than 5 repeat medications, please attach a list.

Medication Name (Generic not branded)	**Dosage**	**Quantity left**

! IMPORTANT INFORMATION REGARDING MEDICATIONS !

- Your child MUST have a medication review before we are able to issue any medications. An appointment will be sent to you via SMS or letter following your child's registration.
- If you are coming from abroad, please have your child's medication information translated and provide evidence that your child is taking this medication with their registration papers.

We now send prescriptions electronically (EPS) to a Pharmacy of your choice. Please pick your desired Pharmacy below;

☐ Rowlands	☐ Consult	☐ Tesco Tring Road	☐ Tesco Broadfields
☐ Boots Hale Leys	☐ Boots Walton Court	☐ Morrisons	☐ Lansdale
☐ Hampden Gardens	☐ Buckingham Park	☐ Lloyds Bedgrove	☐ Lloyds Meadowcroft
☐ Pharmacy 2 U	☐ Other:		

IMMUNISATIONS			
If your child is coming from abroad and this is their first registration at the practice, please complete the immunisation chart below. *NB: If you choose to attach copies of your child's immunisations please have these translated prior to registration.*			
Approximate Age	**Immunisation**	**Date given**	**Country given**
8 weeks	1st Diphtheria, Tetanus, Pertussis		
	1st Polio		
	1st HIB		
	1st Pneumococcal		
	1st Rotavirus		
	1st Meningitis B		
12 weeks	2nd Diphtheria, Tetanus, Pertussis		
	2nd Polio		
	2nd HIB		
	2nd Rotavirus		
	1st Meningitis C		
16 weeks	3rd Diphtheria, Tetanus, Pertussis		
	3rd Polio		
	3rd HIB		
	2nd Pneumococcal		
	2nd Meningitis B		
12 months	HIB/Men C Booster		
	1st MMR (Measles, Mumps, Rubella)		
	3rd Meningitis B		
	3rd Pneumococcal		
3 years, 4 months	MMR Booster		
	Diphtheria, Tetanus, Pertussis & Polio Booster		
12 years upwards	HPV		
	MenACWY		

FAMILY HISTORY

Does your child have a family history of any of the following?

Diabetes Mellitus	☐ Yes, relative: _____	☐ No
Heart Attack	☐ Yes, relative: _____	☐ No
Stroke	☐ Yes, relative: _____	☐ No
Angina	☐ Yes, relative: _____	☐ No
Hypertension (High Blood Pressure)	☐ Yes, relative: _____	☐ No
Breast Cancer	☐ Yes, relative: _____	☐ No
Ovarian Cancer	☐ Yes, relative: _____	☐ No
Bowel Cancer	☐ Yes, relative: _____	☐ No
Lung Cancer	☐ Yes, relative: _____	☐ No

Any other form of Cancer (please state): ……

Online services application for Proxy User Access

e.g. Children under 16 years of age/carers/family members.

Patient for which access is being requested					
Title		First Name		Last name	
Gender	Male/Female			Date of Birth	
Address					

TO BE COMPLETED BY PATIENT			
I give permission to Poplar Grove Practice to give the below named individual/s proxy access to the online services as indicated below. **I reserve the right to reverse any decision I make in granting proxy access at any time.** **I understand the risks of allowing someone else to have access to my health records and I have read and understood the information leaflet provided by the practice.**			
I grant permission to allow access to book appointments and order repeat prescriptions only			
I grant permission to allow access to book appointments, order repeat prescriptions and view online medical records			
***Signature**		**Date**	
Name and relationship (if signed on behalf of patient)			

*If the patient does not have capacity to consent this should be signed by the person holding lasting power of attorney for health andwelfare or by the GP.

Proxy Users applying for access					
Title		First Name		Last name	
Gender	Male/Female			Date of Birth	
Address					
Email					
Relationship to Patient					
Title		First Name		Last name	
Gender	Male/Female			Date of Birth	
Address					
Email					
Relationship to Patient					

TO BE COMPLETED BY THE PROXY USER/USERS APPLYING FOR ACCESS			
I/we understand my/our responsibility for safeguarding sensitive medical information and understandand agree with the following statements *(please tick to indicate agreement):*			
I/we will be responsible for the security of the information that I/we see or download.			
I/we will contact the practice as soon as possible if I/we suspect that the account has been accessed by someone without the patient's agreement.			
If I/we see information in the record that is not about the patient or is inaccurate, I/we will contact the practice as soon as possible, I/we will treat any information which is not about the patient as being strictly confidential.			
Signature		**Date**	
Signature		**Date**	