**CHURCH STREET PRACTICE**

**NEW PATIENT FAMILY DOCTOR REGISTRATION FORM (CHILD)**

**This information will remain strictly confidential. Please make sure you answer all questions and sign the form.**

|  |  |
| --- | --- |
| **PATIENT DETAILS** | **PLEASE COMPLETE IN BLOCK CAPITALS** |
| TITLE: MR/MRS/MISS/MS/DR/OTHER (please state) |  |
| SURNAME: |  |
| FORENAMES: |  |
| PREVIOUS SURNAME(S) |  |
| NHS Number: |  |
| DATE OF BIRTH: |  |
| GENDER: |  |
| TOWN AND COUNTRY OF BIRTH: |  |
| Home Address:  Post Code: | |
| Home Telephone:  **A landline number must be provided if possible**.  Patients aged between 11-15 will not be given access to on-line appointments and mobile phone numbers for their parents will not be recorded or used as text reminders  Mobile Telephone: E-mail: | |
| Have they ever been registered with the Practice before?  Yes No | |
| If you are registering a child under 5 and you wish them to be registered with the doctor for Child Health Surveillance (Health Visitors) please tick the box  More information can be found at <http://patient.info/doctor/healthy-child-programme> | |
| If you are registering a child under 18, please state:  Mother’s Name: Father’s Name  Mother’s Address Father’s Address  Contact Number: Contact Number  Please state who has Parental Responsibility Joint/Mother/Father (delete as appropriate) | |
| Is the child you are registering a young carer and if so who do they care for | |
| **PLEASE HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING INFORMATION** | |
| Your previous address in the UK | Name of preivous doctor while at that address  Address of previous doctor |
| **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 live in UK: |

|  |
| --- |
| Ethnicity  White British  White Irish  White Other  Black African  Black Caribbean  Indian  Pakistani  Bangladeshi  Chinese  Other (please state) \_\_\_\_\_\_\_\_\_\_\_  **What is your first language?**  English  Other (please state language) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * I need the practice to arrange an interpreter for my appointments |
| **CHOICES ABOUT SHARING YOUR INFORMATION** |
| **Choices about sharing your information: If you are completing this for a child who is under 16 but feel they are able to understand this information you should discuss the choices with them.**  **1. Summary Care Record**:  NHS England has introduced the Summary Care Record which is a computerised system which can extract information about any medicines you are taking and allergies you suffer from and make it available to authorised healthcare staff providing your care anywhere in England. More information is available at <http://www.nhscarerecords.nhs.uk/> and in the attached leaflet.  A summary care record will automatically be created for you unless you opt out by ticking the box  **2. Oxfordshire Care Summary:**  The Oxfordshire Care Summary is a secure electronic system which extracts information from Oxfordshire GP and hospital records about medication, allergies, significant diagnoses and tests but the system can only be accessed by authorised clinicians in Oxfordshire to ensure you get the safest treatment as quickly as possible. More information is available at: <http://www.oxfordshireccg.nhs.uk/your-health/oxfordshire-care-summary/> and in the attached leaflet.  An Oxfordshire Care Summary will automatically be created for you unless you opt out by ticking the box |
| **DONOR QUESTIONS** |
| **NHS Organ Donor Registration**  I would like my parent/guardian to consent for me to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick the appropriate box:    Kidneys  Heart  Liver  Corneas  Lungs  Pancreas  Any part of my body    Signature consenting to organ donation Date  ………………………………………………………………………………………………………………………………………………………………………  For more information, please ask for the leaflet on joining the NHS Organ Donor Register |
| **SIGNATURE**  Signed by Patient Signed on behalf of Patient **DATE** |