Perivale Medical Clinic

2 Conway Crescent, Perivale, London, UB6 8HX
Tel: 020 8997 2457 Fax: 020 8810 9489

New Patient Registration Questionnaire (Children under 18)

Welcome to Perivale Medical Clinic! Thank you for taking the time to complete this questionnaire in BLOCK CAPITALS
Your name GP is Dr Narmen Koye

PERSONAL DETAILS	Have you previously been registered at this practice before? ☐ Yes ☐ No
First name:	
Surname:	
Address: Post Code:	
Parent's Home Tel:	Patient's Mobile:
Parent's Mobile:	Patient's email:
Parent's Work Tel:	Main Language (if not English):
Parent's email:	Do you need an interpreter? ☐ Yes ☐ No
What is your preferred telephone number for us to contact you on or leave voicemails?	

ETHNIC ORIGIN	Please tick one box only (recommended categories for National 2011 Census)			
White	**Mixed/Multiple Ethnic**	**Asian / British Asian**	**Black/African/Caribbean/ Black British**	**Other Ethnic Group**
☐ English/Welsh/Scottish /Northern Irish/British ☐ Irish ☐ Gypsy or Irish Traveller ☐ Other White (Specify)……..	☐ White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐ Other Mixed (specify)……..	☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Other Asian (specify)……..	☐ African ☐ Caribbean ☐ Other Black (specify)……..	☐ Arab ☐ Other Ethnic (Specify)…….. ☐ I do not wish to answer this question

NEXT OF KIN	Name: Address (if different from above address) Tel: Post Code: Relationship:

CARERS	Are you a carer for someone else? ☐ Yes ☐ No

Do you have a carer? ☐ No ☐ Yes – Carer's Name:

MEDICAL HISTORY	Please list if you have ever suffered or been treated for any of the following:
Illness : Disabilities: Operations:	
If you have any chronic or significant medical conditions, please book a New Patient appointment to discuss it further.	

FAMILY HISTORY	Please state if any family member has suffered from any of the conditions listed above:				
Illness / Condition	1.	2.	3.	4.	5.
Family Member					
Aged Diagnosed					

MEDICATION	Any allergies to any drugs/medicines?
Are you taking regular medication? ☐ Yes ☐ No If Yes, please list all the medicines, tablets, injections, reams, etc .. you are taking/using Name Dose How often …… …… Please bring to the appointment all your medication (with packaging) and/or your repeat medication request slip from your pre	

VACCINATIONS	Please provide the Personal Child Health Record ("Red Book") or Immunisation records. You can also record any immunisations in the space below		
Date	Immunisation	Date	Immunisation

PARENTAL RESPONSIBILITY

Who has parental responsibility? Father/ Mother/ Both

Sign:

Name:

□ **Please tick if you are signing for both parent and sign again.**
Sign:

YOUR CONSENT MATTER TO US

IF YOU REQUIRED ONE OR ALL OF THE FOLLOWING SERVICES, WE WOULD NEED TO OBTAIN YOUR CONSENT.

Your medication collection/requesting by third party. **Yes ☐**

Please tick who will be collecting or requesting.

Family member ☐ **Carer ☐** **Pharmacy ☐** **Other ☐ Please specify**

Your letter collection/requesting by third party. **Yes ☐**

Please tick who will be collecting/requesting.

Family member ☐ **Carer ☐** **Other ☐ Please specify**

Your appointment made by third party. **Yes ☐**

Please tick who will be making.

Family member ☐ **Carer ☐** **Other ☐ Please specify**

OPT-OUT : YOU CAN CANCEL THE FACILITY AT ANY TIME, IF YOU WISH PLEASE CONTACT US IN WRITING

REPEAT PRESCRIPTION

Requesting : Names **Relationship to you**

1. …… **…….**

2. …… **…….**

Collecting : Names **Relationship to you**

1. …… **…….**

2. …… **…….**

OTHER PAPERWORK

Requesting : Names **Relationship to you**

1. …… **…….**

2. …… **…….**

Collecting : Names **Relationship to you**

1. …… **…….**

2. …… **…….**

BOOKING APPOINTMENTS

Names **Relationship to you**

1. …… **…….**

2. …… **……..**

NAME: **……. DATE OF BIRTH: ……**

SIGNATURE : _____

Privacy Protection

Our practice has a strict confidentiality policy. For more information please visit our website or ask a member of staff.

This information is not shared with any third party organisations.

Your emergency care summary

Summary Care Record – your emergency care summary

The NHS in England is introducing the Summary Care Record, which will be used in emergency care. The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely. Also, if you specifically choose to do so, your Summary Care Record can hold other information you have agreed with your GP Practice to have included.

Your Summary Care Record will be available to authorised healthcare staff providing your care anywhere in England, but they will ask your permission before they look at it. This means that if you have an accident or become ill, the doctors treating you will have immediate access to important information about your health.

For more information talk to our Patient Advice and Liaison Service (PALS) **(**0300 303 5678**),** GP practice staff or visit the website **www.nhscarerecords.nhs.uk**

My Summary Care Record Choice

You are required to fill your name and sign if you are filling out this form on behalf of another person or a child, their GP practice will consider this request.

Your name..... Your signature.....

Relationship to patient ..... Date	**Please** **Tick** ✓
YES I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had	☐
YES I would like a Summary Care Record containing details of my medications, allergies and any bad reactions to medications I have had **AND** any other information that I have agreed with my GP Practice to have included in my Summary Care Records *Please indicate what information you would like adding if you know*	☐
NO I do not want a Summary Care Record	☐

RECORD SHARING – As informed patient, in consultation with a Health Professional, can choose to permit or restrict access to the information entered on their record at each SystemOne organisation at which they receive care. We are one of the SystemOne organisation and therefore you need to make a choice.
The patients consent can be changed at any time.

PLEASE NOTE YOU WILL AUTOMATICALLY BE OPTED IN UNLESS YOU ADVISE OTHERWISE

SHARING OUT

Does the patient consent to the sharing of data recorded here with any organisation that may care for the patient?

☐ Yes – share data with other organisations

☐ No – do not share any data recorded here

SHARING IN

Does the patient consent to viewing of data by this organisation that is recorded at other care services that may care for the patient where the patient has agreed to make the data sharable?

☐ Consent Given

☐ Consent refused

Thank you for completing the questionnaire. New patients over the age of 5 should have a new patient health check with our nurse. Please arrange an appointment now at reception.

I confirm that I have completed this form as accurately and honestly as possible and would like to apply …….. to be registered as a patient at this practice.

Signature: Date: / /

OFFICE USE ONLY	Need Appt? ☐ Yes ☐ No Need Etoh Advice? ☐ Yes ☐ No			**Staff Initials:**
Photo ID	☐ Passport	☐ Driving Licence	☐ Identity Card	☐ Other
Proof of Address	☐ Utility Bill	☐ Tenancy Agreement	☐ Bank Statement	☐ Other