



## New Patient Registration Form – New-born Child

Please complete all pages in full using block capitals

### 1. Background Details

Your Child Details			
Child Name		NHS Number	
Address		Gender	
		Date of Birth	
		Home Telephone	

Parent or Guardian Details (MUST be a registered patient at this practice and residing at the same address)			
Mother or Guardian		Mobile Telephone*	
Father or Guardian		Mobile Telephone	
Address		Home Telephone	
		Work Telephone	
Email*			
Family Registered With Us	Name: Date of birth: Relationship:		

\* by providing a mobile number and/or email address, we assume your consent for contacting you by SMS and/or email

Other Details	
Country of Birth	
Ethnicity	<input type="checkbox"/> White (UK) <input type="checkbox"/> Black Caribbean <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Arabic <input type="checkbox"/> White (Irish) <input type="checkbox"/> Black African <input type="checkbox"/> Indian <input type="checkbox"/> Chinese <input type="checkbox"/> White (Other) <input type="checkbox"/> Black Other <input type="checkbox"/> Pakistani <input type="checkbox"/> Other
Religion	<input type="checkbox"/> C of E <input type="checkbox"/> Buddhist <input type="checkbox"/> Sikh <input type="checkbox"/> Catholic <input type="checkbox"/> Hindu <input type="checkbox"/> Jewish <input type="checkbox"/> No religion <input type="checkbox"/> Other Christian <input type="checkbox"/> Muslim <input type="checkbox"/> Jehovah's Witness <input type="checkbox"/> Other:
Armed Forces	<input type="checkbox"/> Family Member



**Family History**

Please record any significant family history of close relatives with medical problems and confirm which relative e.g. mother, father, brother, sister, grandparent

<input type="checkbox"/> Asthma.....	<input type="checkbox"/> Heart Disease.....	<input type="checkbox"/> Diabetes.....	<input type="checkbox"/> Depression.....
<input type="checkbox"/> COPD.....	<input type="checkbox"/> Stroke.....	<input type="checkbox"/> Kidney Disease.....	<input type="checkbox"/> Thyroid.....
<input type="checkbox"/> Epilepsy.....	<input type="checkbox"/> Blood Pressure.....	<input type="checkbox"/> Liver Disease.....	<input type="checkbox"/> Cancer.....
Other:			

**Parent or Guardian Signature**

Signature	I confirm that the information I have provided is true to the best of my knowledge		
Name		Date	

**2. Prescriptions**

**Electronic Prescribing**

If you would like your prescriptions to be sent electronically, please nominate your preferred pharmacy:

### 3. Sharing Your Health Record

#### Your Health Record

##### Sharing Out

Do you consent to your GP Practice sharing your Child's health record with other organisations who care for them?

- Yes (*recommended option*)  
 No

##### Sharing In

Do you consent to your GP Practice viewing your Child's health record from other organisations that care for them?

- Yes (*recommended option*)  
 No

#### Your Summary Care Record (SCR)

Do you consent to your child having an Enhanced Summary Care Record with Additional Information?

- Yes (*recommended option*)  
 No

#### Parent or Guardian Signature

Signature			
Name		Date	

**Checklist** - Please ensure the following are provided so that your registration can be completed successfully:

- Completed & Signed Above Form
- Completed & Signed GMS1 Form
- Birth Certificate
- Photo Proof of ID *e.g. Passport, Photo Driving License or Photo ID card*
- Proof of Address *e.g. Bank statement, Utility Bill or Council Tax from within the last 3 months*

#### Practice Use Only

Appointment	<input type="checkbox"/> Required	<input type="checkbox"/> Not Required		
Photo ID	<input type="checkbox"/> Passport	<input type="checkbox"/> Driving licence	<input type="checkbox"/> Identity card	<input type="checkbox"/> Other
Proof of Address	<input type="checkbox"/> Utility Bill	<input type="checkbox"/> Council Tax	<input type="checkbox"/> Bank Statement	<input type="checkbox"/> Other

## Sharing Your Health Record

### What is your health record?

Your health record contains all the clinical information about the care you receive. When you need medical assistance it is essential that clinicians can securely access your health record. This allows them to have the necessary information about your medical background to help them identify the best way to help you. This information may include your medical history, medications and allergies.

### Why is sharing important?

Health records about you can be held in various places, including your GP practice and any hospital where you have had treatment. Sharing your health record will ensure you receive the best possible care and treatment wherever you are and whenever you need it. Choosing not to share your health record could have an impact on the future care and treatment you receive. Below are some examples of how sharing your health record can benefit you:

- Sharing your contact details This will ensure you receive any medical appointments without delay
- Sharing your medical history This will ensure emergency services accurately assess you if needed
- Sharing your medication list This will ensure that you receive the most appropriate medication
- Sharing your allergies This will prevent you being given something to which you are allergic
- Sharing your test results This will prevent further unnecessary tests being required

### Is my health record secure?

Yes. There are safeguards in place to make sure only organisations you have authorised to view your records can do so. You can also request information regarding who has accessed your information from both within and outside of your surgery.

### Can I decide who I share my health record with?

Yes. You decide who has access to your health record. For your health record to be shared between organisations that provide care to you, your consent must be gained.

### Can I change my mind?

Yes. You can change your mind at any time about sharing your health record, please just let us know.

### Can someone else consent on my behalf?

If you do not have capacity to consent and have a Lasting Power of Attorney, they may consent on your behalf. If you do not have a Lasting Power of Attorney, then a decision in best interests can be made by those caring for you.

### What about parental responsibility?

If you have parental responsibility and your child is not able to make an informed decision for themselves, then you can make a decision about information sharing on behalf of your child. If your child is competent then this must be their decision.

### What is your Summary Care Record?

Your Summary Care Record contains basic information including your contact details, NHS number, medications and allergies. This can be viewed by GP practices, Hospitals and the Emergency Services. If you do not want a Summary Care Record, please ask your GP practice for the appropriate opt out form. With your consent, additional information can be added to create an Enhanced Summary Care Record. This could include your care plans which will help ensure that you receive the appropriate care in the future.

### How is my personal information protected?

The Surgery Bull Yard will always protect your personal information. For further information about this, please see our Privacy Notice on our website or please speak to a member of our team

For further information about your health records, please see: [www.nhs.uk/NHSEngland/thenhs/records](http://www.nhs.uk/NHSEngland/thenhs/records)

For further information about how the NHS uses your data for research & planning and to opt-out, please see: [www.nhs.uk/your-nhs-data-matters](http://www.nhs.uk/your-nhs-data-matters)