

NEW PATIENT REGISTRATION QUESTIONNAIRE

PATIENT INFORMATION

Name:	Date of birth:
Tel No:	Mobile No:
Email:	Ethnicity:
First language:	Interpreter required: Yes / No
What is your religion?	
We text patients with appointment reminders and information about our services. Are you happy for us to contact you in this way?	Yes / No

EMERGENCY CONTACT / NEXT OF KIN DETAILS

Name:	Contact No:
Relationship to you:	
If you wish to give consent/permission for the Practice to discuss your medical record/problems with a family member/friend? Please give details below:-	
Name:	Tel No.
Email:	Relationship to you:

BASIC HEALTH:

Height:	Weight:
<ul style="list-style-type: none"> Do you have any allergies? Please list any current repeat medications:- Please list any relevant medical history/problems:- 	

ARMED FORCES:

Have you been registered with an Armed Forces GP before?	
What role were you registered as?	
What was your enlistment date?	
What was your leaving date from the Forces?	

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COMMUNICATION NEEDS

Do you have any communication, mobility or other needs? Yes No

If yes, please specify:-

CARER DETAILS – if you tick yes to any carer questions please speak with a member of the reception team

Are you a Carer?	<input type="checkbox"/> Yes – Informal/unpaid	<input type="checkbox"/> Yes – Occupational/Paid	<input type="checkbox"/> No
Do you have a Carer?	<input type="checkbox"/> Yes Name: _____ Tel: _____		Relationship: _____

SUMMARY CARE RECORD (SCR)

Do you consent to sharing a summary of your GP care record (SCR) with authorised care professionals, ie NHS 111, 999 and A&E Departments?

- Yes (*recommended option*)
 No

No – I do not want a Summary Care Record and express dissent (opt out) for a Summary Care Record (select this option if you DO NOT want any information shared with other healthcare professionals involved in your care).

SHARING OF HEALTH RECORDS – IN & OUT

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

- Yes (*recommended option*)
 No

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

- Yes (*recommended option*)
 No

Patient Signature:	Date:
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STAFF SECTION ONLY

Name:	Date:
Documents seen for online services:	

New Patient Questionnaire

(Addendum for Children Only)

Immunisation Record

Before we register your child at the Practice we need some up to date immunisation information from you. Please fill in the dates when your child received any of the immunisations below. The information will be in their 'Red Book'; alternatively, if you call their last GP Surgery, they will be able to give you the dates.

Child's Name:

Date of Birth:

NHS No:

Age due	Immunisations Given	Date Given
2 months old	Diphtheria/Tetanus/Whooping cough/Polio/Hib	
	Pneumonia (PCV)	
	Rotavirus	
	Meningitis B	
3 months old	Diphtheria/Tetanus/Whooping cough/Polio/Hib	
	Rotavirus	
4 months old	Diphtheria/Tetanus/Whooping cough/Polio/Hib	
	Pneumonia	
	Meningitis B	
12-13 months old	Measles/Mumps/Rubella	
	Hib/Men C	
	Pneumonia	
	Meningitis B	
3 years 5 months old	Measles/Mumps/Rubella	
	Diphtheria/Tetanus/Whooping cough/Polio/Hib	

Signed by Parent/Guardian:



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Print Name:

Date: