**Dr V Patel Surgery**

**9 Glanville Drive, Hornchurch, RM11 3SZ (01708 442117)**

[**www.drvpatelsurgery.nhs.uk**](http://www.drvpatelsurgery.nhs.uk)

**In order to be fully registered with Dr V Patel, this form MUST be completed by the parent/guardian**

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| **NEW PATIENT HEALTH QUESTIONNAIRE (FOR CHILDREN UNDER 6Y)** | | | | | | | | | | | | | |
| **TITLE:** |  | | | | **FIRST NAME:** | | | |  | | | | |
| **SURNAME:** | |  | | | | | | | | | | | |
| **DATE OF BIRTH:** | |  | | | | | | | **GENDER:** | | | **M**  **F** (please tick) | |
| **ADDRESS (incl flat no):** | | | | | | | **ANY OTHER SURGERY PATIENTS LIVING AT THIS ADDRESS?** | | | | | **Please give names:** | |
|  | | | | | | |
| **HOME TEL:** | |  | | | | | | **MOBILE TEL:** | | | |  | |
| **EMAIL ADDRESS:** | |  | | | | | | | | | | | |
| **WHO DO THESE DETAILS BELONG TO? (e.g. mum, dad etc.)** | | | | **MOBILE:** | | | |  | | | | | |
| **EMAIL:** | | | |  | | | | | |
| **CAN WE LEAVE MESSAGES REGARDING YOUR CHILD ON THESE NUMBERS?** | | | | **HOME:** | | | | **YES  NO** (please tick) | | | | | |
| **MOBILE:** | | | | **YES  NO** (please tick) | | | | | |
| **NEXT OF KIN:**  **(Name, Address, Tel No.)** | | | |  | | | | | | | | | |
| **PREVIOUS ADDRESS:** | | | | | | | | **PREVIOUS GP NAME & ADDRESS:** | | | | | |
|  | | | | | | | |  | | | | | |
| **Pharmacy Details (name and address of preferred pharmacy)** | | | | | | | | | | | | | |
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| --- | --- |
| **Summary Care Record Consent** | |
| **Medication, allergies and adverse reactions only** | **YES  NO** (please tick) |
| **Medication, allergies, adverse reactions and additional** | **YES  NO** (please tick) |
| **Dissent – Patient does not want a summary care record** | **YES  NO** (please tick) |

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| --- | --- | --- | --- | --- | --- |
| MEDICAL HISTORY | | | | | |
| **Has your child had/still have any of the following conditions?** (please tick) **:** | | | | | |
| **High Blood Pressure**  (Please add approximate date of diagnosis if known) | **YES  NO** | **Diabetes**  (Please add approximate date of diagnosis if known) | | | **YES  NO** |
| **Heart Disease**  (Please add approximate date of diagnosis if known) | **YES  NO** | **Angina**  (Please add approximate date of diagnosis if known) | | | **YES  NO** |
| **Epilepsy**  (Please add approximate date of diagnosis if known) | **YES  NO** | **Stroke**  (Please add approximate date of diagnosis if known) | | | **YES  NO** |
| **Asthma**  (Please add approximate date of diagnosis if known) | YES  NO | **Cancer**  (Please add approximate date of diagnosis if known) | | | **YES  NO** |
| **If Asthmatic**, have you used your inhaler in past 12 months? | **YES  NO** |
| **Please give details of any other illnesses, accidents, hospital admissions, investigations or operations your child has had :** | | | | | |
|  | | | | **Date:** | |
|  | | | | **Date:** | |
|  | | | | **Date:** | |
| **MEDICATION** | | | | | |
| **IS YOUR CHILD ON ANY REGULAR MEDICATION?** | | | **YES  NO** (please tick) | | |
| If Yes, please state name and dose or attach the most recent repeat reorder form (Please note they will be required to see the doctor for a first repeat prescription to be issued) | | | | | |
| **IS YOUR CHILD ALLERGIC TO ANY MEDICINES?** | | | **YES  NO** (please tick) | | |
| **If Yes, please state type and name:** | | | | | |

Please note **without immunisation history we are unable to fully register children**. A current photocopy of the immunisation history is the preferred option; we can take a photocopy of this at reception. If this is not available then please list below.

|  |  |
| --- | --- |
| **IMMUNISATIONS** | **DATE GIVEN** |
| 1st Diphtheria, Tetanus, Pertussis (Whooping Cough) / Polio / Hib |  |
| 2nd Diphtheria, Tetanus, Pertussis (Whooping Cough) / Polio / Hib |  |
| 3rd Diphtheria, Tetanus, Pertussis (Whooping Cough) / Polio / Hib |  |
| 1st Rotavirus |  |
| 2nd Rotavirus |  |
| 1st Meningitis B |  |
| 2nd Meningitis B |  |
| 3rd Meningitis B |  |
| 1st Meningitis C |  |
| 2nd Meningitis C (if applicable) |  |
| 3rd Meningitis C (if applicable) |  |
| 1st Pneumococcal conjugate |  |
| 2nd Pneumococcal conjugate |  |
| 3rd Pneumococcal conjugate |  |
| Other Pneumococcal (if applicable) |  |
| Hib / Meningitis C |  |
| 1st Measles, Mumps, Rubella (MMR) |  |
| Booster Diphtheria, Tetanus, Pertussis (Whooping Cough) / Polio / Hib |  |
| Booster Measles, Mumps, Rubella (MMR) |  |
| BCG |  |
| Details of any other immunisations: |  |

**Does your child have a disability?**  Yes  No  Decline to specify

The Disability Discrimination Act 1995 states ‘a person has a disability for the purpose of this ACT if he/she has a physical or mental impairment, which has a substantial and long-term adverse effect on his/her ability to carry out day to day duties.

**Ethnic Origin**

This is not about nationality, place of birth or citizenship. It is about the group to which you perceive your child belongs. Please tick the appropriate box

**White**

English  Welsh  Scottish  Northern Irish  Irish  British  Prefer not to say  Any other white background, please write in:

**Mixed/multiple ethnic groups**

White and Black Caribbean  White and Black African  White and Asian  Prefer not to say  Any other mixed background, please write in:

**Asian/Asian British**

Indian  Pakistani  Bangladeshi  Chinese  Prefer not to say 

Any other Asian background, please write in:

**Black/ African/ Caribbean/ Black British**

African  Caribbean  Prefer not to say 

Any other Black/African/Caribbean background, please write in:

**Other ethnic group**

Prefer not to say  Any other ethnic group, please write in:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Is an interpreter or sign language support needed? | **Yes** |  | **No** |  |

**Patient Services**

We offer an online service for our patients so you can book your appointments, order your repeat prescriptions and have online access to your medication history and allergies online at your convenience.

**Online appointment booking**

Have the flexibility to book and cancel your appointments from home, at work or any location with internet access. You don’t need to queue at the practice, wait on the telephone and you can manage your appointments outside practice opening hours.

**Request your repeat prescriptions online**

Request your repeat prescriptions quickly online by logging into your account and simply ticking the appropriate boxes. You can review the progress of your repeat prescriptions and any message that the practice may have sent to you.

**Access to your GP record online**

Take greater control of your health and wellbeing by being able to view your medication history, allergies and adverse reactions online.

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**Patient Services - Patient registration form**

To register please complete the form below and return it to the practice in person, **along with a valid form of identification (e.g. photo ID or your passport).** Once registered we will give you the information that will enable you to create a username and password.

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| **Patient details** | **Please complete in BLOCK CAPITALS** | | | | | | | | | | | | | | | | | | | |
| Patient forename |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Patient surname |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Date of birth | D | D | / | M | M | / | Y | Y | Y | Y |  | | | | | | | | | |
| Email address  **This email address will be used by your practice to send you notifications and reminders.** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | | | | | | | | | | | | | | | | | | | |
| Mobile number |  |  |  |  |  |  |  |  |  |  |  |  | | | | | | | | |
| Signature |  | | | | | | | | | | | | | | | | | | | |
| Date | D | D | / | M | M | / | Y | Y | Y | Y |  |  |  |  |  |  |  |  |  |  |
| **Completing the form on behalf of the patient?** | | | | | | | | | | | | | | | | | | | | |
| Print forename |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Print surname |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Relationship to patient |  | | | | | | | | | | | | | | | | | | | |
| Signature |  | | | | | | | | | | | | | | | | | | | |
| Date | D | D | / | M | M | / | Y | Y | Y | Y |  | | | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Staff use only** |  | | | | | | | | | | |
| Patient ID seen |  | | | | | | | | | | |
| Type of ID |  | | | | | | | | | | |
| Staff name |  | | | | | | | | | | |
| Date | D | D | / | M | M | / | Y | Y | Y | Y |  |

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Dear Parent

In order to ensure the continuation of the health visiting service we ask you to complete this form. This information will then be passed on to your Health Visitor.

Thank you.

**Mother’s name: ………………………………………………………**

**Father’s name: ………………………………………….……………**

**Children’s names, dates of birth & School/Nursery attended:**

**……………………………………………………………….……………**

**……………………………………………………………….……………**

**……………………………………………………………….……………**

**……………………………………………………………….……………**

**……………………………………………………………….……………**

**Present Address & Tel No. …………………………….……………**

**……………………………………………………………….……………**

**……………………………………………………………….……………**

**Previous GP and address of surgery:**

**……………………………………………………………….……………**

**……………………………………………………………….……………**

**………………………………………………………………..……………**

**Comments/information the health visitor needs to know:**

**……………………………………………………………………………….**

**…………………………………………………………………..……………**