New Patient Registration Form
(Children: under 16s)

ST MARY'S SURGERY
Church Close, Andover, Hants, SP10 1DP
01264 361424 www.stmaryssurgery.co.uk

1. Complete a separate form for each child to be registered
2. Complete in BLOCK CAPITALS and tick the boxes as appropriate

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Full Name:			Date of Birth: / /
Title : ☐ Master	☐ Miss	☐ Other *(Please state)*:	Gender: ☐ Male ☐ Female
NHS number if known:			Home tel. number:
Address: Postcode:			Mobile tel. number: We will use this to send appointment reminders etc. Please tick here if you do not wish to receive messages from us: ☐ Email address: Please indicate your preferred contact method: Letter ☐ Email ☐ SMS (text) ☐ Phone ☐
If child has come from abroad, the date they entered the UK: / /			
Country and Place of birth:	Country: Town/City:		
Previous Full UK Address: Postcode:			Previous GP Practice: Postcode:
Is the child home educated? ☐ Yes ☐ No			
Name of child's nursery/school:			
Comments:			

Parent/Guardian Details *(We are unable to register your child if this information is not completed)*

Name:	Name:
Relationship to child:	Relationship to child:
Date of Birth: / /	Date of Birth: / /
Contact tel.number: ☐ Yes ☐ No	Contact tel.number:
Are you next of kin? ☐ Yes ☐ No	Are you next of kin? ☐ Yes ☐ No
Do you have legal responsibility? ☐ Yes ☐ No	Do you have legal responsibility? ☐ Yes ☐ No
Registered with the Surgery? ☐ Yes ☐ No	Registered with the Surgery? ☐ Yes ☐ No
Same Address as child? ☐ Yes ☐ No *If no, please write full address below:*	Same Address as child? ☐ Yes ☐ No *If no, please write full address below:*

Is the child currently: ☐ A Refugee ☐ An Asylum Seeker

Is the child a child in care or a "Looked After Child"? ☐ Yes ☐ No

If yes, in what capacity?

☐ With family members ☐ Temporary ☐ Other: .....
.....
☐ With registered foster carers ☐ Permanent .....

Has the child or family either currently or in the past been known to Children's Services?

☐ Yes ☐ No

Name of Social Worker:

Social Worker's tel. no:

Is the child being privately fostered (*see definition below*)? ☐ Yes ☐ No

If yes, please provide carer's name:
Carer's relationship to child:
Contact details of carer:

Are Children's services aware? ☐ Yes ☐ No

Private fostering is an arrangement whereby a child under the age of 16 (or 18 if the child has a disability) (S.66 Children Act 1989) is placed for 28 days or more in the care of someone who is not the child's parent(s) or a 'connected person'. Private foster carers can be from the extended family, e.g. a cousin or a great aunt, but cannot be a relative as defined under the Children Act 1989, section 105:*'A relative under the Children Act 1989 is defined as a 'grandparent, brother, sister, uncle or aunt (whether full blood or half blood or by marriage or civil partnership) or step-parent'.*

	Please list any other residents of your home who are registered with the Surgery:	
	Name:	Relationship to child:

2	Parent / Guardian permission given	
	Permission given for someone other than a Parent/Guardian to accompany your child to an appointment?	
	Name of person/s: Relationship:	Parent / Guardian Signature:

3	<u>Young Carers</u>	
	Is your child looking after someone at home? If so, who?	Yes ☐ No ☐
	Do you think the child would like additional support as a young carer? Is the child known to services such as Young Carers?	Yes ☐ No ☐ Yes ☐ No ☐

4 <u>Contacting you</u>

We will use your contact details to send reminders about appointments, reviews and other services which may be of benefit in your child's medical care

Do you consent to the Surgery sending letters to your home address? Do Yes ☐ No ☐

you consent to the Surgery sending text messages to your mobile? Do Yes ☐ No ☐

you consent to the Surgery sending messages to you by email? Do you Yes ☐ No ☐

consent to the Surgery leaving messages on your phone? Yes ☐ No ☐

5 <u>Health Professionals</u>

Does your child have contact with any of the following? *Please specify name/contact.*

A hospital specialist ☐ .....

A health visitor ☐ .....

A social worker ☐ .....

Any other health professionals ☐ .....

6	<u>Service Families and Military Veterans</u>	
	As a practice, we fully support the Armed Forces Covenant. We can only do this if we know our patients' connections to the Armed Forces. Please tick the below boxes that apply to you:	
	☐ One or both parent(s) are serving member(s) of the armed forces.	☐ One or both parent(s) are Military veteran(s)

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Religion (Please tick)	☐ C of E	☐ Catholic	☐ Other Christian * _____	☐ Bhuddist	☐ Hindu ☐ Muslim
	☐ Sikh	☐ Jewish	☐ Jehovah's Witness	☐ No religion	☐ Other religion * _____

Ethnic Origin (Please tick one)	☐ White (UK)	☐ White (Irish)	☐ White (Other)
☐ Black Caribbean/British	☐ Indian/British Indian	☐ Arabic	☐ Other Mixed Background
☐ Black African / British	☐ Pakistani ☐ British	☐ Chinese	☐ Other Asian Background
☐ Other Black Background	☐ Bangladeshi / British Bangladeshi	☐ Other	☐ Ethnic Category Refused

What is your child's main spoken language? Do they speak English? Yes ☐ No ☐	Do they need an Interpreter? Yes ☐ No ☐

Disabilities / Accessible Information Standards

As a practice we want to make sure that we can communicate clearly with your child. For that reason we would like to know if your child has any communication needs.

Does your child have any special communication needs that you would like us to be aware of?

☐ Lip reading	☐ Large print	☐ Hearing aid	☐ British sign language (BSL)	☐ Makaton sign language
☐ Braille	☐ Other *(Please state)* * _____			

Does your child have any physical needs that you would like us to be aware of when it comes to arranging appointments etc?

☐ Wheelchair/ mobility scooter	☐ Walking aid	☐ May require assistance	☐ Other *(Please state)* * _____

Other comments:

8 Health and Medical Information

Please enter your child's height in		Please enter your child's weight in	
Feet / inches:	cm:	Kilos/grams:	Stones / lbs:

If under 5 years old, type of Birth:
(eg normal, forceps, caesarean)

Other comments:

9 Medical History

Are there any serious diseases that affect your child's parents, brothers or sisters? Tick all that apply *and* state family member:

Diabetes ☐ Who:	Asthma ☐ Who:	Thyroid disorder ☐ Who:	Stroke ☐ Who:	COPD ☐ Who:
Heart Attack under age of 60 ☐ Who:	Cancer (Specify type) ☐ Who:	High Blood pressure ☐ Who:	Any other important family illness. *Please state*: Who:	

Please state any allergies and sensitivities that your child has to medicines, food & dressings:		
Does your child have any problems taking medicines?	Yes ☐ No ☐	*If yes* please give details, e.g. swallowing

Does your child have any chronic medical conditions?

Diagnosis:	Date of Diagnosis:	Name of consultant/specialist (if applicable):

Has your child had any operations?	Date of operation/s:
Has your child had any significant injuries?	Date of injury/s

Please list any tablets, medicines or other treatments your child is currently taking / undertaking:

Name of medication	What condition is it for?	How many and how often	Dose/strength

Please state your preferred pharmacy for prescriptions to be sent:

10 **Covid Vaccination Status**

First Vaccination	Date given:	Type:	Location given:
Second Vaccination	Date given:	Type:	Location given:

11	Which vaccinations has your child had?				
Age	Immunisation	Date (DD/MM/YY)	GP Surgery	Private	Abroad
2 months	1st Diphtheria, Tetanus, Pertussis		☐	☐	☐
	1st Polio		☐	☐	☐
	1st HIB		☐	☐	☐
	1st Pneumococcal Vaccine		☐	☐	☐
	1st Rotavirus		☐	☐	☐
3 months	2nd Diphtheria, Tetanus, Pertussis		☐	☐	☐
	2nd Polio		☐	☐	☐
	2nd HIB		☐	☐	☐
	1st Meningitis C		☐	☐	☐
	2nd Rotavirus		☐	☐	☐
4 months	3rd Diphtheria, Tetanus, Pertussis		☐	☐	☐
	3rd Polio		☐	☐	☐
	3rd HIB		☐	☐	☐
	2nd Pneumococcal Vaccine		☐	☐	☐
	2nd Meningitis C		☐	☐	☐
12 months	Hib/Men C Booster		☐	☐	☐
13 months	MMR (Measles, Mumps, Rubella)		☐	☐	☐
	3rd Pneumococcal Vaccine		☐	☐	☐
3½ to 5 years	MMR Booster (Measles, Mumps, Rubella)		☐	☐	☐
	Pre- School Booster Diphtheria, Tetanus, Pertussis & Polio		☐	☐	☐

12	Sharing Medical Record *Please be aware that you may have to complete additional forms in order to decline or "opt out".*
	Medical Record Sharing: Allows your child's complete medical record to be made available to authorised healthcare professionals involved in their care. If you do not want to share your child's GP record tick here: ☐
	Summary Care Record: Contains details of your child's key health information – medications, allergies and adverse reactions. They are accessible to authorised healthcare staff in A&E Departments throughout England. If you do not want to have a Summary Care Record for your child tick here: ☐ For more information: Phone 0300 123 3020 or visit www.nhscarerecords.nhs.uk

13	NHS (Charges to Overseas Visitors) Regulations Self Declaration
	My child is a British resident and entitled to full NHS care ☐ My child is not ordinarily resident in the UK ☐ For more information and guidance, please go to www.nhs.uk or www.gov.uk. Please complete the next form if your child is not a British resident or you are unsure of their current status.

Patient Declaration for all patient who are not ordinarily resident in the UK

Patient's details

Please complete in BLOCK CAPITALS and tickick ☑

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth | | | | | | | | |

First names

NHS No. | | | | | | | | | | |

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

Patient Declaration for all patients who are not ordinarily resident in the UK

Anybody in England can register with a GP practice and receive free medical care from that practice.

However, if you are not 'ordinarily resident' in the UK you may have to pay for NHS treatment outside of the GP practice. Being ordinarily resident broadly means living lawfully in the UK on a properly settled basis for the time being. In most cases, nationals of countries outside the European Economic Area must also have the status of 'indefinite leave to remain' in the UK.

Some services, such as diagnostic tests of suspected infectious diseases and any treatment of those diseases are free of charge to all people, while some groups who are not ordinarily resident here are exempt from all treatment charges.

More information on ordinary residence, exemptions and paying for NHS services can be found in the Visitor and Migrant patient leaflet, available from your GP practice.

You may be asked to provide proof of entitlement in order to receive free NHS treatment outside of the GP practice, otherwise you may be charged for your treatment. Even if you have to pay for a service, you will always be provided with any immediately necessary or urgent treatment, regardless of advance payment.

The information you give on this form will be used to assist in identifying your chargeable status, and may be shared, including with NHS secondary care organisations (e.g. hospitals) and NHS Digital, for the purposes of validation, invoicing and cost recovery. You may be contacted on behalf of the NHS to confirm any details you have provided.

Please tick one of the following boxes:

a) ☐ I understand that I may need to pay for NHS treatment outside of the GP practice

b) ☐ I understand I have a valid exemption from paying for NHS treatment outside of the GP practice. This includes for example, an EHIC, or payment of the Immigration Health Charge ("the Surcharge"), when accompanied by a valid visa. I can provide documents to support this when requested

c) ☐ I do not know my chargeable status

I declare that the information I give on this form is correct and complete. I understand that if it is not correct, appropriate action may be taken against me.

A parent/guardian should complete the form on behalf of a child under 16.

Signed:		Date:	DD MM YY
Print name:		Relationship to patient:	
On behalf of:			

Complete this section if you live in another EEA country, or have moved to the UK to study or retire, or if you live in the UKbut work in another EEA member state. Do not complete this section if you have an EHIC issued by the UK.

Non-UK European Health Insurance Card (EHIC), Provisional Replacement Certificate (PRC) Details and S1 Forms

Do you have a non-UK EHIC or PRC?	Yes: ☐ No: ☐	If yes, please enter details from your EHIC or PRC below:
	Country Code:	
	3: Name	
	4: Given Names	
	5: Date of Birth	DD MM YYYY
	6: Personal Identification Number	
	7: Identification number of the institution	
	8: Identification number of the card	
	9: Expiry Date	DD MM YYYY
PRC validity period (a) From:	DD MM YYYY	(b) To: DD MM YYYY

If you are visiting from another EEA country and do not hold a current EHIC (or Provisional Replacement Certificate (PRC))/S1, you may be billed for the cost of any treatment received outside of the GP practice, including at a hospital.

Please tick ☐ if you have an S1 (e.g. you are retiring to the UK or you have been posted here by your employer for work or you live in the UK but work in another EEA member state). Please give your S1 form to the practice staff.

How will your EHIC/PRC/S1 data be used? By using your EHIC or PRC for NHS treatment costs your EHIC or PRC data and GP appointment data will be shared with NHS secondary care (hospitals) and NHS Digital solely for the purposes of cost recovery. Your clinical data will not be shared in the cost recovery process.

Your EHIC, PRC or S1 information will be shared with The Department for Work and Pensions for the purpose of recovering your NHS costs from your home country.

Patient Checklist

Thank you for completing this form. Please check you have completed all sections where possible. Please ensure that you bring the following with you to the surgery to complete your child's registration:

1. **Completed & Signed New Patient Registration Questionnaire** (this form!) ☐
2. **Proof of ID** - either passport or birth certificate (if under 5 years). ☐
3. **Proof of Legal Responsibility (if applicable)** - such as court order/foster carer paperwork etc. ☐
4. Your child's **Immunisation Records** – usually the Personal Child Health Record ("Red Book") ☐
5. If relevant, your child's **Repeat Medication Request Slip** from their previous GP ☐

Patient Agreement

- I agree to ensure that my child attends on time for all appointments booked with the Practice and to cancel in advance any appointment that they cannot attend. I acknowledge that should they arrive late foran appointment they may be asked to wait until the end of surgery or have to rebook for another time.
- I understand that the appointments are for 10 minutes only and, to be fair to other patients waiting, the doctor/nurse may only be able to deal with one problem during this time.
- I agree to request repeat prescriptions on 5 working days' notice of my child's need for medication. I agreeto make the request either in person, by letter or through the website/NHS app. I acknowledge that requests cannot be made by telephone.
- I agree not to behave in an abusive, threatening or otherwise aggressive manner to any member of the practice staff. I am aware that the practice operates a zero tolerance policy and I acknowledge the right of the practice to request that another nominated adult brings my child to appointments if I engage in such behaviour.
- I confirm that I have completed this form as accurately and honestly as possible and would like to apply for my child to be registered as a patient at this practice.

Signature:	Date:
Printed name:	Relationship to patient:

We the Practice declare that we shall not disclose any information regarding the patient without the patient or their guardian's written consent.

We are registered under the Data Protection Act 2018 and have robust systems in place to protect your confidentiality. For more information, please see our website.

Office use only

Received by:	Date:
Patient ID etc. checked by:	Date:
Registration completed by:	Date:

Within Catchment?	☐ Yes ☐ In existing patient household		LAC/Child Protection/etc?	☐ Yes - task sent to MC ☐ No
Photo ID seen:	☐ Passport	☐ Birth certificate	☐ Identity card	☐ Other
Living with adult:	☐ Parent	☐ Relative	☐ Guardian (paperwork checked)	
Nominated GP:	☐ Patient advised		☐ Patient not advised (add reminder to record)	

Covid Vaccination Status:	☐ Yes ☐ No	☐ Coded ☐ Task sent
Patient Declaration Completed:	☐ Yes ☐ No	☐ Emailed