MINSTER MEDICAL PRACTICE
Dr Christopher Batty, Dr Paul Fitzgerald, Dr Puneet Mehrotra, Dr Ayham Zanoun
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NEW PATIENT REGISTRATION FORM – UNDER 16 YEARS OF AGE

Welcome to Minster Medical Practice. Please help the Doctors by completing this questionnaire as fully and as accurately as possible.

PATIENT DETAILS DATE_____

Mr Mrs Miss Ms Other		Surname	
Date of Birth		First Name(s)	
NHS No		Previous Name(s)	
Home Address			
Postcode			
Home Tel No		Mobile Tel No	
Preferred No	Home ☐ Mobile ☐ Other:		
First Language		Country of Birth	
Ethnicity: (Please tick the most appropriate box)	British of Mixed British	Irish	
	Indian or British Indian	Chinese	
	Pakistani or British Pakistani	Caribbean	
	Bangladeshi or British Bangladeshi	African	
	White & Black Caribbean	Other Black background	
	White & Black African	Other White background	
	White & Asian	Other Asian background	
	Ethnic category withheld	Other mixed background	

PARENTAL RESPONSIBILITY – Please list all person who have parental responsibility (mother/father/guardian) and anyone who may bring the patient to appointments on behalf of the parent/s. Please include their relationship to the patient.

Name	
Relationship to patient	
Address	
Contact Tel No	
Name	
Relationship to patient	
Address	
Contact Tel No	

SMS/EMAIL CONSENT – On occasion we may wish to contact you via text message or email, for example to send confirmation of appointment date and time or for health related messages.

I ***GIVE*** consent for Minster Medical Practice to contact me via text message or email.	
Signature:	Date:
I ***DO NOT GIVE*** consent for Minster Medical Practice to contact me via text message or email.	
Signature:	Date:

Please remember to update the Practice if you change your telephone number or email address.

NHS PATIENT INFORMATION SHARING – Please find enclosed leaflets for Summary Care Record and Electronic Patient Record Sharing IN and OUT. Please read these fully.

I ***CHOOSE*** to have a NHS Summary Care Record	
Signature:	Date:
I ***DO NOT CHOOSE*** to have a NHS Summary Care Record	
Signature:	Date:

I ***GIVE*** consent for Minster Medical Practice to ***SHARE IN*** my electronic patient record	
Signature:	Date:
I ***DO NOTGIVE*** consent for Minster Medical Practice to ***SHARE IN*** my electronic patient record	
Signature:	Date:

I ***GIVE*** consent for Minster Medical Practice to ***SHARE OUT*** my electronic patient record	
Signature:	Date:
I ***DO NOTGIVE*** consent for Minster Medical Practice to ***SHARE OUT*** my electronic patient record	
Signature:	Date:

PHARMACIES – In order to have your Prescription sent electronically to a Pharmacy please tick your choice below.

Co-op Cabourne		Co-op Burton Road	
Co-op St Boltophs (South Park)		Co-op Winning Post (Monks Rd)	
Boots High Street		Boots Carlton Centre	
Tesco		Watsons	
Jhoots (Brayford)		Daytom	
Other (Please state)			

ADDITIONAL COMMUNICATION REQUIREMENTS – Does your child have any specific communication needs? By leaving this section blank we ***WILL NOT*** record alternative communication methods in your record. Please only tick the boxes that apply.

Braille Grade 1		Braille Grade 2	
British Sign Language		Contact via carer/third party	
Verbally (telephone) only		Email only	
Text message only		Large print font	
Interpreter	(Please state language)		
Other	(Please state other)		

Height	Metres	Weight	Kg

FAMILY MEDICAL HISTORY

Has the patients parent(s) or sibling(s) suffered from any of the problems listed below – please circle the family member and write the age at which they were diagnosed.

Asthma	Father / Mother / Sister / Brother	Age:
Blood Pressure (high / Low)	Father / Mother / Sister / Brother	Age:
Cancer	Father / Mother / Sister / Brother	Age:
Diabetes	Father / Mother / Sister / Brother	Age:
Heart Attack	Father / Mother / Sister / Brother	Age:
Stroke	Father / Mother / Sister / Brother	Age:

MEDICAL HISTORY – Please tick if your child has a history of any of the following:

Cancer		Depression or Mental health problems	
Dementia or Alzheimer's		Kidney Disease	
Hypertension (High blood pressure)		Heart failure, Coronary Heart Disease or Atrial Fibrillation	
Asthma or COPD		Learning Difficulties	
Diabetes		Thyroid Disease	
Epilepsy		Stroke or Transient Ischemic Attacks	
If they have any other history, important illnesses or disabilities not mentioned above, please give details here (include diet requirements)			

ALLERGIES

Please list any allergies the patient has:	

MEDICATION

REPEAT MEDICATION: If your child is currently taking any repeat medication, please list it below. You will need to book a review appointment with a GP to re start your medication. Please make sure the child has enough supply to last for a month

YOUR DETAILS – Where this form has not been completed by the patient, please provide details below:

Name of person completing form:	
Relationship to patient	
Signature	
Date	

"Do you look after someone who wouldn't be able to get by on their own?"

Who is a Young Carer?

Anyone under the age of 18 who cares for a friend or family member (who could not cope without their help) is a Carer. Reasons someone might need help could be: Illness, Disability, Old Age, a Mental Health Problem or an Addiction.

Why Join the Practice Carers Register?

We know that while rewarding, being a Carer can be hard. In order to provide help and support to Adult and Young Carers we need Carers to Self-Identify. This means that the Practice can offer you help and information both in terms of additional NHS care and signposting to Carer charities.

I look after someone who wouldn't be able to get by on their own

YOUR DETAILS (Carer)

Name	
Date of Birth	
Address	
Postcode	
Telephone Number	
Name of your GP Surgery	

Please tick this box if you are in receipt of **Carer's Allowance** (You will need to provide evidence of this if having a Free NHS Flu Jab) ☐

Please tick this box if you would like the practice to consider your eligibility for a Free NHS Flu Jab ☐

I LOOK AFTER MY .....(Patient Details)

Name	
Date of Birth	
Nature of Illness/Disability	
Name of your GP Surgery	

Anyone can register as a Carer. If you feel that you look after someone who would struggle without your help please complete the form above to *enable us to better support you*.

MINSTER MEDICAL PRACTICE
SUPPORTING YOUNG CARERS

Patient checklist for completing the registration form:

NHS Number (can be obtained from previous GP Practice) ☐

Contact details (address, telephone number and email) ☐

Previous GP details ☐

Proof of address ☐

Photo ID ☐

Return forms to the Practice with proof of address and ID ☐

Practice checklist when form returned by patient:

Photo ID ☐

Proof of Address ☐

Address within our catchment area ☐

Telephone numbers ☐

NHS Number ☐

Town and Country of birth ☐

Previous GP ☐

Full previous address ☐

SMS consent ☐

Summary Care Record consent ☐

Sharing in and out preferences ☐

New patient health check ☐

Smoking and alcohol status ☐

Checked by ……. Date……..