**AELFGAR SURGERY**

**Church Street, Rugeley, Staffs, WS15 2AB**

**Tel: 01889 579276**

**www: aelfgarsurgery.co.uk**

CHILD NEW PATIENT QUESTIONNAIRE

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PERSONAL DETAILS** | | | | | | |
| SURNAME : |  | FORENAME : | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| DATE OF BIRTH: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | | |  | |
| ADDRESS : |  |  | | |  | |
|  |  |  | | |  | |
| POSTCODE : |  |  | | |  | |
| TEL NO : | (HOME) :\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | (MOBILE) : | | |  | |
| EMAIL : | | |  | | | |
| Do you consent to text/email reminders? | | | YES |  | NO |  |
| Is this child on the child protection register? | | | YES |  | NO |  |
| Is this child under a special guardianship order? | | | YES |  | NO |  |
| Is this child a looked after child? | | | YES |  | NO |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Who has Parental Responsibility?** | |  |  |  |  |
| Name : | Name : | | | | |
| Address : | Address : | | | | |
| Telephone number : | Telephone number : | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **In order that we may take into account a patient’s culture, religion and background when providing appropriate individual care, your assistance in completing this section is greatly appreciated as it helps us to improve our policies and procedures** | | | |
| White British |  | Pakistani |  |
| White Irish |  | Bangladeshi |  |
| White Other |  | Other Asian background |  |
| White & Black Caribbean |  | Black Caribbean |  |
| White & Black African |  | Black African |  |
| White & Asian |  | Other Black background |  |
| Other Mixed Background |  | Chinese |  |
| Indian |  | Any other |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Height and Weight** | | | | |
| Height :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Weight :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
|  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| **Assistance During Appointments** | | |
| In order for us to provide your child with any assistance they may require during consultations, please let us know if they would benefit from any of the following:- | | |
| First Language NOT English – require a translator  Spoken language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Deafness – require a sign language translator |  |  |
| Disability – require a carer |  |  |
| Our practice has a standard with regards to communicating with you and can use a variety of methods in order to do this. To ensure we promote the effective and clear policy by which ever means is appropriate to the circumstances, we would be most grateful if you could advise us if your child requires any of the following :   |  |  | | --- | --- | | Tick as appropriate | √ | | Requires Audible Alert |  | | Using British Sign Language |  | | Requires information by email |  | | Requires written information in large font |  | | Requires information in Grade 1 Braille |  | | Requires information in Grade 2 Braille |  | | | |

**IDENTIFICATION DOCUMENTS REQUIRED WHEN REGISTERINGAS A NEW PATIENT**

When returning the completed registration form, please bring your proof of identification.

**PROOF OF NAME**

**(One of the following)**

Birth Certificate

Marriage Certificate

Driving Licence (valid)\*

Passport (valid)\*

**PROOF OF ADDRESS;MUST BE DATED WITHIN THE LAST 3 MONTHS**

**(One of the following)**

Utility Bill

Council Rent Book

Bank Statement

Credit Card Statement

Letter from Benefits Agency

**\*Please note if applying for Online Access to your medical records, photo ID must be produced.**

**Information for our patients.**

**We're improving how we communicate with patients.**

**Please tell us if you need information in a different format or need communication support.**



**Application for online access to my medical record**

|  |  |
| --- | --- |
| Surname | Date of birth |
| First name | |
| Address  Postcode | |
| Email address | |
| Telephone number | Mobile number |

I wish to have access to the following online services (please tick all that apply):

|  |  |
| --- | --- |
| 1. Booking appointments |  |
| 1. Requesting repeat prescriptions |  |
| 1. Accessing my medical record |  |

I wish to access my medical record online and understand and agree with each statement (tick)

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice |  |
| 1. I will be responsible for the security of the information that I see or download |  |
| 1. If I choose to share my information with anyone else, this is at my own risk |  |
| 1. If I suspect that my account has been accessed by someone without my agreement, I will contact the practice as soon as possible |  |
| 1. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible |  |
| 1. If I think that I may come under pressure to give access to someone else unwillingly I will contact the practice as soon as possible. |  |

|  |  |
| --- | --- |
| Signature | Date |

**For practice use only**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient NHS number | | Practice computer ID number | |
| Identity verified by  (initials) | Date | Method Vouching  Vouching with information in record  Photo ID and proof of residence | |
| Authorised by | | Date | |
| Date account created | | | |
| Date passphrase sent | | | |
| Level of record access enabled  All  Prospective  Retrospective  Detailed coded record  Limited parts | | | Notes / explanation |

|  |  |
| --- | --- |
| **FOR PRACTICE USE ONLY** Checked By (Initials) | |
| Registration Form completed and signed |  |
| New Patient Questionnaire completed |  |
| SCR option selected (Opt-Out Form completed if dissent given) |  |
| ID Verified and photocopied |  |
| New Patient Health Check appt made |  |
| Check if requesting online access and if so sign to say you have seen ID |  |
| Communication Template completed |  |