#  New Patient Questionnaire 5-16 year olds

It is important that we have your **correct Name and Address**, so that we can operate an efficient filing system. We would be grateful if you would take the time to complete the form below as fully as you can. If in the future any of these details change, please let us know. **The questionnaire NEEDS to be completed in full before registration can go ahead.**

**Surname: ………………………………………………………………………………………….**

**Forename(s): …………………………………………………………………………………….**

**Date of Birth: …….../ ……... / …………**

Preferred contact preference: Please circle one or more  **EMAIL □ TELEPHONE □ EXT □ MESSAGE □**

***Ethnic Origin:*** *(Please tick appropriate)*

**White British □ Irish □**

**White & Black Caribbean □ White & Black African □**

**White & Asian □ Indian □**

**Pakistani □ Caribbean □**

**African □ Chinese □**

**Bangladeshi □ Other □**

**Not wishing to give information □**

**If other please state: ……………………………………………………………….**

***Main Language:*** *(Please tick appropriate)*

**English □ Polish □ Hindi □**

**Punjabi □ German □ Italian □**

**Urdu □ Thai □ Czech □**

**British sign language □ Not wishing to give information □**

**If other please state……………………………………………………………….**

**Do you require an interpreter YES □ NO □**

**Height………………………. Weight………………………**

**IMPORTANT - Please give details of Next of Kin**

**Name…**……………………………………………………………………………………………………

**Address…**…………………………………………………………………………………………………

**Telephone Number**……………………………………………………………………………………...

**Relationship** ………………………………………………………………………………………………

**Signature…**………………………………………………………………………………………………...

**IMPORTANT- Please give details if you are Carer/Legal Guardian**

Name……………………………………………………………………………………………………….

Address……………………………………………………………………………………………………...

Telephone Number………………………………………………………………………………………...

Relationship…………………………………………………………………………………………………

Signature……………………………………………………………………………………………………

**The practice is looking for patients to join the Patient Participation Group.**

**If you are interested please ask at reception for more details.**

**PATIENTS CURENT CONSENT PREFERENCE**

**(IMPLIED CONSENT FOR MEDICATION, ALLERGIES AND ADVERSE REACTIONS -SHARE WITH OTHER HEALTH PROFESSIONALS i.e. out of hours)**

**Please select one option only**

1. EXPRESS CONSENT FOR MEDICATION, ALLERGIES AND ADVERSE REACTIONS

ONLY

|  |
| --- |
|  |

1. EXPRESS CONSENT FOR MEDICATION, ALLERGIES AND ADVERSE REACTION AND

ADDITIONAL INFORMATION

|  |
| --- |
|  |

1. EXPRESS DISSENT (OPT OUT) – YOU DO NOT WANT A SUMMARY CARE RECORD

|  |
| --- |
|  |

Signature of/on behalf of Patient……………………………………………………………………………

Date……………………………………………………………………………………………………………

**PROXY CONSENT FORM**

**[request for patient access details on behalf of another person]**

|  |  |
| --- | --- |
| Patient Details  | PROXY Details |
| Name: | **Name:** |
| Address: | **Address:** |
| Post Code: | **Post code:** |
| Telephone: | **Telephone:** |
|   | Email (Mandatory): |
| Mobile: | **Mobile:** |
| Date of Birth: | **Date of birth:**  |
|  | **Relationship:** |

I give permission the above named to have access to my medical records and personal details held by the Practice via the Online Services – Patient Access.

I the patient wish the above named to have access to: Tick all that apply.

|  |  |
| --- | --- |
| 1. Online appointment booking
 |  |
| 1. Online prescription management
 |  |
| 1. Access to my medical record
 |  |

I understand that this consent will remain in force indefinitely. However, my doctor may, at my request, override this authority to allow access to my medical records via the Patient Access/Online Services at any time. I understand the risks of allowing someone else to have access to my medical records.

**Signed**.............................................................................. parent/Guardian

Date..................................................................................

I will treat any information provided confidentially, I will not disclose information to a third party without agreement and will only use the information in the person that I have proxy access for in their best interest.

Date...................................................................................

(Staff Only - FORM PASSED FOR SCANNING ONTO PATIENT RECORD INITIALS & DATE