**Broadway Surgery New Patient Registration – Children Between 0 – 12y**

**Please complete all sections in FULL using BLOCK capital letters.**

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| **Your Child’s Details** |
| Title | Mr [ ]  Mrs [ ]  Miss [ ]  Ms [ ]  Other [ ]  |
| Surname |  |
| First Name(s) |  |
| Previous Surname (if applicable) |  |
| Date of Birth (dd/mm/yyy) |  | NHS Number |  |
| Gender | Male [ ]  Female [ ]   |
| Town & Country of Birth |  | Date you came to live in the UK if born abroad: |  |
| Address |  |
| Previous Address |  |
| Telephone Number |  | Mobile Number |  |
| Email address |  |
| Contact/Communication Preference | Letter [ ]  Email [ ]  SMS [ ]  No Preference [ ]   |
| **Personal Medical History** |
| Name of your previous GP surgery |  |
| Address of previous GP surgery |  |
| Type of Birth (if under 5) | Normal[ ]  Forceps[ ]  Caesarean[ ]  |
| Birth Weight (if under 5) |  | Feeding (if under 5): | Breast[ ]  Bottle fed[ ]   |
| Has your child ever suffered from any important medical illness, operation or admission to hospital?  | If so, please state: |
| Have any close relatives (mum, dad, sister, brother ONLY) ever suffered from: | High blood pressure[ ]  Diabetes[ ]  Heart Attack[ ]  Stroke[ ]  Cancer[ ]  Asthma[ ]  Glaucoma[ ]  Other[ ]  If other, please state: |
| Please provide details of your child’s immunisations with dates if possible (under 5’s) | [ ] Tetanus: Date [ ] Tetanus Booster: Date[ ] Whooping Cough: Date [ ] Diptheria Booster: Date[ ] Polio: Date [ ] Polio Booster: Date[ ] MMR: Date [ ] MMR Booster: Date[ ] HiB: Date[ ] Measles: Date[ ] BCG (TB): Date[ ] Meningitis: Date |
| Allergies |  |
| List of Current Medication |  |
| **About Your Child** |
| Ethnicity | White British[ ]  Irish[ ]  Other White Background[ ]  White & Black African[ ]  White & Black Caribbean[ ]  Other Mixed Background[ ]  Indian or British Indian[ ]  Pakistani or British Pakistani[ ]  Bangladeshi or British Bangladeshi[ ]  Other Asian Background[ ]  Black British[ ]  African[ ]  Caribbean[ ]  Chinese[ ]  Other[ ] If other, please state: |
| Main Spoken Language  |  | Do they speak English? | Yes [ ]  No [ ]  |
| Height (m) |  | Weight (kg) |  |
| Next of Kin Name |  |
| Relationship to Next of Kin |  |
| Next of Kin Tel. Contact Number |  | Are they registered here? | Yes [ ]  No [ ]  |
| **Consent and Data Sharing** |
| To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). **Do you give us your consent to share certain medical information with other hospitals?**Yes [ ]  No [ ] Where you have provided information on how to contact you, can you confirm you are happy for The Broadway Surgery to contact you by the following:By email Yes [ ]  No [ ]  This will be to send you letters, newsletter and the like.By text Yes [ ]  No [ ]  This will be to send you reminders of appointments via text |
| I can confirm that the information I have provided is true to the best of my knowledge. |
| Signature |  | Date |  |
| Signature of Patient [ ]  Signature on behalf of patient [ ]  |