PLEASE RETURN THIS FORM TO RECEPTION AFTER COMPLETION

CROSS DEEP SURGERY

NEW PATIENT REGISTRATION FORM

THIS FORM MUST BE COMPLETING IN FULL

FAILURE TO COMPLETE EVERY SECTION COULD RESULT IN A DELAY TO YOUR REGISTRATION

For Babies & Children Under 6 Years

*Mothers Name:*_____ *Mothers Date of Birth:*_____

(A) Patients FULL Name:_____

Date of Birth:_____ NHS No (If Known): _ _ _ _ _ _ _ _ _ _ _ _

Address:_____

_____

Telephone Home:_____ Work:_____ Mobile:_____

Email Address: _____

(EMAIL ADDRESSED MUST BE PERSONAL – DO NOT GIVE SHARED EMAIL ADDRESSES)

Next of Kin:_____ Relationship: _____

Address Next of Kin:_____

Telephone Next of Kin:_____

(Ai) Online appointments and request repeat prescriptions service is **not available for patients under 16 Years**

(Aii) ☐ I would like to Opt out of having a Summary Care Record. (#9Ndo)

(Aiii) ☐ I would like to Opt out of data extraction. (#9Nu0 & #9Nu4)

Note: If you are Unsure about Sections Aii & Aiii then we advise patients to read the information available from our website and in our waiting area in order to make an informed decision – You can opt out and opt back in at any time. If you are opting out your child then you must make them aware of their choices to opt back in when they reach a suitable age to make an informed decision to do so.

Signature_____ Date_____

(B) ETHNIC INFORMATION

This is important as certain diseases are more prevalent among people for particular areas of the world. We should be very grateful if you would tick the most appropriate category for you.

Ethnic Category		*Tick here:*	*Additional Comments:*
WHITE	British		
	Any other White (please state)		
BLACK/BLACK BRITISH	Caribbean		
	African		
	Any other Black (please state)		
ASIAN / ASIAN BRITISH	Indian		
	Pakistani		
	Bangladeshi		
	Any other Asian (please state)		
MIXED ORIGIN	White & Black Caribbean		
	White & Black African		
	White & Asian		
CHINESE	Chinese		
ANY OTHER GROUP	Please State:		
PATIENT REFUSAL			

(C) Main Language that will be spoken: _____

(D) IMMUNINSATION HISTORY

	Immunisations	*Given (Tick)*	*Date Given:*
2 Months	- Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (5 in 10) - Pneumococcal - Rotavirus		
3 Months	- Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (5 in 10) - Meningitis C - Rotavirus		
4 Months	- Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (5 in 10) - Pneumococcal		
Between 12-13 Months	- Meningitis C / #4 Haemophilus influenzae type b (Combined) - Measles, Mumps & Rubella - #Pneumococcal		
Between 3 – 4 Years	- Measles, Mumps & Rubella - Diphtheria, tetanus, pertussis and polio (4 in 1 – Preschool Booster)		
List below any other vaccines given:			

(E) Please list:

(i) Any important medical problems:_____

_____

(ii) Any Medication:_____

_____

(iii) Any family History of diabetes, heart disease or cancer:_____

_____

(iiii) Any Allergies:_____

_____

_____