Southernhay House Surgery

New Patient Registration Document

New Born Baby

Welcome to Southernhay House Surgery

New Baby Registration Questionnaire

Please ensure that you fill out **all** of the following information

Baby Details

Forename(s)	Surname
Gender: (please circle) Male / Female	
Current Address: (Please include Post Code)	

Who else lives in this household?	Full Name	Relationship to child
……..	……	……..
……..	……...	……..
……..	……	……
……..	……	……
……..	……	……

Date of Birth:	NHS Number:
Home Tel Number:	Mobile Number:
Place of Birth:	Religion:

Parent/Guardian Details

Name:	Contact Number:
Relationship to Child:	Religion:
Can we leave messages, (including text messages) regarding your child on the telephone numbers provided?	Home **Yes** **No** Mobile **Yes** **No** (Please circle)

Next of Kin

Name:	Contact Number:
Relationship to your baby:	

Ethnicity and Language

The NHS requires all medical records to show a patient's ethnic origin

Please tick your baby's ethnic group

White: British or Mixed British		Asian: Pakistani or British Pakistani	
White: Irish		Asian: Bangladeshi or British Bangladeshi	
White: Any other background		Black: Caribbean	
Mixed: White and Black Caribbean		Black: African	
Mixed: White and Black African		Black: Any other background	
Mixed: White and Asian		Chinese	
Mixed: Any other background		Any other ethnic group (please specify)	
Asian: Indian or British Indian			

If you will **need a translator** at your baby's appointment, please inform us of the language you require: _____

Clinical Information

Family Medical History

Do any of the following illnesses run in your baby's family? Please tick as appropriate:

Diabetes		Angina	
Asthma		Osteoporosis	
High Blood Pressure		Other Hereditary Disease (please specify type)	
Stroke		Heart Disease	
High Cholesterol		Cancer (please specify type)	
Epilepsy			

Personal Medical History

Does your baby / has your baby ever suffered with any of the following illnesses? Please tick as appropriate:

Diabetes	Type I Type II		Angina	
Asthma If YES has your baby used inhalers in the last 12 months?				
High Blood Pressure			Other Hereditary Disease (please specify)	
Stroke			Heart Disease	
High Cholesterol			Cancer (please specify type)	
Epilepsy			Osteoporosis	
HAVE YOUR BABY EVER HAD ANY OTHER ILLNESSES, ACCIDENTS, HOSPITAL ADDMISSIONS, INVESTIGATIONS OR OPERATIONS? (please circle and specify below) **Yes** **No**				
Date: **Date:** **Date :**				

Allergies

Does your baby have any severe allergies? **No / Yes (please list below)**

1.	3.
2.	4.

Child Protection

Has your baby been placed on the Child Protection Register? (Please circle)

Yes **No**

Smoking

Does anyone in the household smoke? (Please circle) **Yes** **No**

Smoking in the presence of children is a health risk. If you, or anyone in your household, would like help and advice to give up smoking please tick box ☐

If you answered YES please call 01884 836024 for further information.

Medication

Is your baby taking any regular medication? **Yes** **No**

If YES please specify which medications your baby takes on a regular basis below.

Medication	**Dose**	**How many times daily**
1.		
2.		
3.		
4.		

Pharmacies

If your baby requires repeat prescriptions, and you would like to collect your baby's prescription directly from a pharmacy rather than the surgery, please specify below which pharmacy you would like your baby's prescription sent to. Please note that **ONLY** the pharmacies specified are able to provide this service for our surgery.

Sainsburys	Guildhall		**Day Lewis**	Summer Lane	
	Pinhoe			Beacon Lane	
Lloyds	Heavitree		**Well Pharmacy**		
	Magdalen Road		**St Leonards**		
	Sidwell Street		**Tesco**		
Boots	High Street		**Superdrug**		
	Exe Bridges		**Pinhoe Pharmacy**		

I confirm that all information given is correct and completed to the best of my ability.

If you have completed the Registration Pack on behalf of a child please PRINT and SIGN here:

Full Name	
Parent/Guardian of	
Signature	

Southernhay House Surgery

Patient Application for Online Access to My Medical Record

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

*Please note including your email address gives us consent to use it.

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

1. Booking appointments	
2. Requesting repeat prescriptions	
3. Accessing my medical record	

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

I have read and understood the information leaflet provided by the Practice	
I will be responsible for the security of the information that I see or download	
If I choose to share my information with anyone else, this is at my own risk	
If I suspect that my account has been accessed by someone without my agreement	
If I see information in my record that is not about me or is inaccurate I will contact the Practice as soon as possible	
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 login details provided			
Level of record access enabled All Prospective Retrospective Detailed coded record Limited parts		Notes / explanation	