# Primrose Hill Surgery – Registration Form (Child)

# Registration times between 14:30 – 17:00 Mon - Fri

# *Please complete in BLOCK CAPITALS and mark as appropriate and complete ALL questions where applicable*

**Patient’s Details**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Title** | |  | | | | **Surname** | |
| **Date of Birth**  **[DD/MM/YYYY]** | | | |  | | **First name** | **Middle name/s** |
| **NHS No.** |  | | | | | **Previous Surname/s** | |
| **Male** | | | **Female** | | **Other** | **Town & Country of Birth** | |
| **Ethnic Origin** | | | | | | **School / Nursery** | |

**Contact Details**

|  |  |
| --- | --- |
| **Home Address** | |
| **Postcode** | **Telephone Number** |
| **Email Address** | |
| **At Primrose Hill, patients who have provided us with an email address may receive personal medical information by email. They may also receive information on public health initiatives and patient meetings. If you do not want to be contacted in this way you can now or anytime in the future unsubscribe by emailing primrosehillsurgery@nhs.net .** | |

**Please help us trace your previous medical records by providing the following information**

|  |  |
| --- | --- |
| **Your previous address in UK** | **Name of Previous Doctor while at that address** |
| **Address of previous doctor** |

**If you are from abroad**

|  |  |
| --- | --- |
| **Your first UK Address where registered with a GP** | |
| **If previously resident in UK,**  **Date of leaving** | **Date you first came to live in UK** |

**If you are registering a child under 5**

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| --- |
| **I wish the child above to be registered with Primrose Hill Surgery for Child Health Visiting Services.** |

**Parent / Carers Name**

|  |  |
| --- | --- |
| **Parent / Carer Name 1** | **Contact Details** |
| **Parent / Carer Name 2** | **Contact Details** |

**Height & Weight**

|  |  |  |  |
| --- | --- | --- | --- |
| **Height** | **cm**  **feet & inches** | **Weight** | **kg**  **lb** **stone** |

**Smoking**

|  |  |  |
| --- | --- | --- |
| **Do you smoke?** **Yes**  **No** | **How many cigarettes do you smoke a day?** | **Would you like help to quit?**  **Yes**  **No** |
| **If no, have you ever smoked?**  **Yes**  **No** | **If Yes, How many cigarettes did you  smoke a day?** | **How long did you smoke for & when did**  **you stop?** |

**Sexual Health Screening (16+)**

|  |  |
| --- | --- |
| **Would you like a FREE HIV test?**  **Yes**  **No** | **Would you like a FREE Chlamydia test? (16-25)**  **Yes**  **No** |
| **To obtain your free test, contact reception for further instructions.** | |

**NHS Organ Donor Registration**

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| --- |
| **I want to register my details on the NHS Organ Donor Registry as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.**  **Any of my organs and tissue or**  **Kidneys** **Heart** **Liver**  **Corneas** **Lungs**  **Pancreas**  **Any part of my body**  **Signature confirming my agreement to organ/tissue donation:** **Date** \_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Accessible Information**

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| --- |
| **Do you have any information and communication support needs? For example, would you like information in Large Print or Easy Read format? Do you use a hearing aid or communicate in British Sign Language? Do you need a language interpreter?**  **Please tell us your preferences:**    **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Other health information**

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| --- |
| **Do you have any allergies, or had bad reactions to anything? Are you taking any prescribed medications? Is there any information you think we should know? Let us know here (if you need more space please continue on a blank sheet of paper):**    **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Data Sharing Initiatives**

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| --- | --- | --- | --- | --- |
| **Camden Integrated Digital Record [CIDR]**  Enables your Camden care providers, when they are treating you, to view your GP record, and allows your GP to view the record of other Camden providers that also use CIDR.  This enables clinicians involved in your care to see a more complete medical record when they are treating you. You will be asked for consent before your CIDR record can be opened. | | **Summary Care Record [SCR]**  If you have a Summary Care Record your health care providers can view your medication, bad reactions to medications and allergy information when treating you in an emergency or when your practice is closed.  **Additional optional information includes:** significant medical history, reason for medication, anticipatory care information, end of life care information, immunisations. | | |
| **Opt In:**  **Automatic** | **Opt Out:**  **Ask at reception** | **Opt in:**  **Automatic** | **Opt in + additional:** | **Opt Out:** |

**I confirm that the above information is complete and correct to the best of my knowledge**

|  |  |
| --- | --- |
| **Signature** | **Date** |
| **Print name** | **Relationship to patient** |

**Thanks for registering!**

**Hand this form in to reception or email to primrosehillsurgery@nhs.net**

It takes up to 5 working days to process your registration.

If you are registering a child under 5 years, please bring in their red book after their registration has been processed.