# NEW PATIENT REGISTRATION FORM– CHILD

*NO IDENTIFICATION NEEDED FOR CHILDREN UNDER THE AGE OF 16*

*ALL PAPERWORK TO BE COMPLETED BY PATIENTS PARENT OR GUARDIAN*

WESTBOURNE MEDICAL CENTRE

**ADMIN USE ONLY:**
Form accepted on: (date) .....
Form accepted by: (initials) .....
Entered on SystmOne on: (date) .....
Entered on SystmOne by: (initials) .....

## Patients Details:

**First Name** .....

**Surname** .....

**NHS no** .....

**Date of Birth** .....

**Address** .....
.....
.....
Postcode .....

**Contact Phone Number**
Preferred
Mobile ..... ☐
Home ..... ☐

**Ethnicity** .....

**First Language** .....

**Place of Birth** .....

**Height** .....

**Weight** .....

## Next of Kin / Emergency Contact:

**Full Name** .....
.....

**Relation to you** .....

**Contact Phone Number**
Mobile .....
Home .....

**Address** .....
.....
.....
Postcode .....

## Nursery/ School:

**Name and Address if possible** .....
.....
.....

## Electronic Prescription Service (EPS):

**Please nominate a pharmacy for us to send your prescriptions to electronically**

.....
.....

**Tick NO if you do not wish to use EPS** ☐ **NO**

## Text Messaging:

I acknowledge that information including appointment reminders sent by text are an additional service, not under the control of the practice and that the practice cannot guarantee that a message will always be sent. I understand that the practice does not respond to replies on its SMS text service. I agree to advise the practice if my mobile number changes.

I consent to being contacted via text message: **YES** ☐ **NO** ☐

## Declaration:

In order for you to be registered with this practice you must be 'lawfully living in the UK, voluntarily for a settled purpose' for over 3 months and reside in the practice area.
**Please confirm that you fulfil these criteria by signing this form.**

**Signature:**..... **Date:** .....

☐ Signed on behalf of patient (Relationship to patient .....)

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## Family Members:

Is there anyone registered with us, living at the same address?
If **YES,** please complete below for further details:

| | FAMILY MEMBER 1 | FAMILY MEMBER 2 |
|---|---|---|
| **Full Name** | ..... | ..... |
| **Relation to you** | ..... | ..... |
| **Date of Birth** | ..... | ..... |

| | FAMILY MEMBER 3 | FAMILY MEMBER 4 |
|---|---|---|
| **Full Name** | ..... | ..... |
| **Relation to you** | ..... | ..... |
| **Date of Birth** | ..... | ..... |

## Other information:

| | |
|---|---|
| Are you a current smoker? | YES / NO |
| If YES, how many per day? | ..... |
| **Smoke Stop:** If you would like advice on how to stop smoking please visit www.livewelldorset.co.uk or phone 0800 840 1628 or 01305233105 | |
| If you no longer smoke, when did you stop? | ..... |

**Previous GP details**

Name .....

Town .....

County .....

**Why did you leave your last Practice?**

- Moved out of area ☐
- Unhappy with service ☐
- Other (Please specify)..... ☐

**Why did you choose Westbourne Medical Centre?**

- Good reputation/ recommended ☐
- Closest location/ Convenient ☐
- Tried other local practices but not accepted ☐
- Other (Please specify)..... ☐

**Are you a carer or cared for?** .....

If you are a carer or are being cared for please speak to Reception for more information about the carers register and support services available to you.

## Accessible Information Standard Communication Needs:

Do you have any special communication needs?

**YES** ☐
NO ☐

If **YES,** further details .....

If **YES,** what is your preferred method of communication?

- Letter ☐
- Email ☐
- Telephone ☐
- Braille: Grade 1 ☐ Grade 2 ☐
- Written: Font 12 ☐
- Font 20 ☐
- Font 28 ☐

**Signature:**..... **Date:** .....

☐ Signed on behalf of patient (Relationship to patient .....)