



**NEW PATIENT QUESTIONNAIRE**  
**UNDER 16 YEARS OLD**

Please complete as many questions as you can about your child. The information will help the practice to provide better medical care for your family.

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**PERSONAL DETAILS:**

Mr/Miss/Other (please specify): .....

First Name: ..... Surname: .....

DOB: ..... NHS No: .....

Address: .....

.....

..... Postcode: .....

Patient Mobile No (if applicable): .....

Please provide the names of Parent(s) or Carer(s) who have parental responsibility for the patient:

Parent/Carer 1: ..... Contact No: .....

Parent/Carer 2: ..... Contact No: .....

Completed by: ..... Date: .....

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**PLEASE COMPLETE ALL QUESTIONS BELOW**

1. Does your child have any disabilities? .....
2. Does your child have any special requirements e.g. Hearing aid/wheelchair access/partially sighted?  
.....
3. Is your child a carer for a relative?: Yes / No

## **NHS YOUR DATA MATTERS**

If you do not want your confidential patient information to be used beyond your individual care please go to: [www.nhs.uk/your-nhs-data-matters](http://www.nhs.uk/your-nhs-data-matters) to learn more and manage your choice online. Alternatively you can call the NHS Digital Contact Centre on 0300 303 5678 between 9am to 5pm Monday to Friday (excluding bank holidays).

You must have an email address or phone number registered with an NHS service to continue online. You will need:

- your NHS number
- to have access to your email or mobile phone
- to be aged over 13 years old

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## **MEDICAL HISTORY**

If your child has been diagnosed with any of the following medical conditions, please detail the year of diagnosis.

Asthma:		Epilepsy:	
Diabetes (if so type):		Mental Health:	
Other illness / or operations:			

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## **ETHNIC GROUP** (Please tick):

British:	<input type="checkbox"/>	Irish:	<input type="checkbox"/>	Asian:	<input type="checkbox"/>
African:	<input type="checkbox"/>	Caribbean:	<input type="checkbox"/>	Bangladeshi:	<input type="checkbox"/>
Chinese:	<input type="checkbox"/>	Indian:	<input type="checkbox"/>	Pakistani:	<input type="checkbox"/>
Other (please specify):				Do not wish to answer:	<input type="checkbox"/>

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## **FIRST LANGUAGE SPOKEN** (Please tick):

English:	<input type="checkbox"/>	Other (please detail):	<input type="checkbox"/>
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## **DRUGS & TREATMENT**

Which local pharmacy would you like to collect future prescriptions from? (Please tick):

Lowick (Brackley):	<input type="checkbox"/>	Co-op (Middleton Cheney):	<input type="checkbox"/>
Lark Rise (Brackley):	<input type="checkbox"/>	Sainsbury's (Banbury):	<input type="checkbox"/>
Boots (Brackley):	<input type="checkbox"/>	Other:	<input type="checkbox"/>

1. Is your child allergic to any medication? Yes / No

If yes, please detail:.....

2. Does your child have any allergies? Yes / No

If yes, please detail:.....

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## Recommended Consent Options for New patient Registration Forms

### Consent for Summary Care Record

The Summary Care Record (SCR) is a snapshot of your GP medical record which holds details of medication, allergies and adverse reactions and with your permission the practice can add any additional information you request i.e. Angina diagnosis. This may also include information detailing any health issues which you and your GP considers important to your wellbeing.

The Summary Care Record (SCR) is used by other NHS organisations such as A&E and Out Of Hours, and these organisations can only access this information with your permission. There maybe circumstances where staff cannot ask you for example if you are unconscious, therefore healthcare staff may look at your record without asking you.

For more information please ask Reception for an information leaflet.

### Summary Care Record Consent Options

<b>Please tick ONE option only:</b>	
I consent for medication, allergies and adverse reactions only	<input type="checkbox"/>
I consent for medication, allergies and adverse reactions <b>AND</b> additional information	<input type="checkbox"/>
I request for my clinical information to be withheld from the Summary Care Record (Opt out form attached)	<input type="checkbox"/>



Your emergency care summary

CONFIDENTIAL

# OPT-OUT FORM

## Request for my clinical information to be withheld from the Summary Care Record

If you **DO NOT** want a Summary Care Record please fill out the form and send it to your GP practice

### A. Please complete in BLOCK CAPITALS

Title ..... Surname / Family name .....

Forename(s) .....

Address .....

Postcode..... Phone No..... Date of birth .....

NHS Number (if known)..... Signature .....

B. If you are filling out this form on behalf of another person or a child, their GP practice will consider this request. Please ensure you fill out their details in section A and your details in section B

Your name ..... Your signature.....

Relationship to patient..... Date .....

### What does it mean if I **DO NOT** have a Summary Care Record?

NHS healthcare staff caring for you may not be aware of your current medications, allergies you suffer from and any bad reactions to medicines you have had, in order to treat you safely in an emergency.

Your records will stay as they are now with information being shared by letter, email, fax or phone.

If you have any questions, or if you want to discuss your choices, please contact your GP practice.

FOR NHS USE ONLY

Actioned by practice: yes / no

Date.....