



**Registration Form Age 0-16 yrs.  
PLEASE COMPLETE THIS FORM IN FULL USING  
BLOCK CAPITALS**

To process your registration, form we will require a copy of your Birth Certificate

Have you ever been registered at this practice before? Yes  No

Contact Information	
Child's name	
Date of Birth	
Parents name	
Telephone number	

**I consent to receiving SMS text messages from Scott Road Medical Centre regarding appointment reminders and relevant health invitations. (Please tick)**

Consent

Dissent

We occasionally use your email address to communicate with you about your direct medical care.

We can also email you other useful information unrelated to your direct medical care - for example surgery newsletters, surgery information, staff changes and minutes from patient participation meetings. If you would like to receive this information, please consent below.

**I consent to receiving emails from Scott Road Medical Centre regarding Non-medical information (Please Tick)**

We never pass your email onto any third parties (unless you have given us your explicit consent to do so) You can withdraw consent at any time by informing Reception.

**Do you have repeat Medication?**

<b><u>Nominate a pharmacy</u></b>	Pharmacy Name & Location
We now send all prescriptions electronically to your preferred pharmacy, please nominate a pharmacy.	

<b>Specific Needs: This is to enable us to accommodate your needs. Please specify any specific requirements you may require below.</b>	
<b>Please state any Sensory Impairment you have (i.e., Speech, Hearing, Sight)</b>	
<b>Are you an assistant dog user?</b>	
<b>Please state any Physical/Mental disabilities?</b>	
<b>Do you have any access requirements?</b>	
<b>Do you have any phobias?</b>	



**Are you a Carer?**

<p><b>If you have a Carer, please state their name / address / phone number and sign here if you wish us to disclose information about your health to your Carer.</b></p>	<p><b><u>Carer Contact Details:</u></b></p>
<p><b>If you are a Carer, please state your name/address/phone number of the person who you care for:</b></p>	<p><b><u>Person Cared for Contact Details:</u></b></p>

Ethnicity			
<b>White</b>	British	<input type="checkbox"/>	XaJQv
	Irish	<input type="checkbox"/>	XaJQw
	Any other white background	<input type="checkbox"/>	XaJQx
<b>Mixed</b>	White & Black Caribbean	<input type="checkbox"/>	XaJQy
	White & Black African	<input type="checkbox"/>	XaJQz
	White & Asian	<input type="checkbox"/>	XaJR0
	Any other mixed background	<input type="checkbox"/>	XaJR1
<b>Asian or British Asian</b>	Indian	<input type="checkbox"/>	XaJR2
	Pakistani	<input type="checkbox"/>	XaJR3
	Bangladeshi	<input type="checkbox"/>	XaJR4
	Any other Asian background	<input type="checkbox"/>	XaJR5
<b>Black or Black British</b>	Caribbean	<input type="checkbox"/>	XaJR6
	African	<input type="checkbox"/>	XaJR5
	Any other background	<input type="checkbox"/>	XaJR8
<b>Any Other Ethnic Background</b>	Chinese	<input type="checkbox"/>	XaJR9
	Any other (please describe)		XaJRA
<b>Please state your first language</b>			



Family History - Please tick ANY box that applies to you	<i>Please confirm which family member</i>
A member of my family suffers from Diabetes Family member who suffers from this condition e.g., Father, Mother, Brother, Sister	<input type="checkbox"/>
A member of my family suffers from Hypertension Family member who suffers from this condition e.g., Father, Mother, Brother, Sister	<input type="checkbox"/>
A member of my family suffers from heart disease, and this started BEFORE they were 60 years of age Family member who suffers from this condition e.g., Father, Mother, Brother, Sister	<input type="checkbox"/>
A member of my family suffers from Asthma Family member who suffers from this condition e.g., Father, Mother, Brother, Sister	<input type="checkbox"/>

Patient Participation Group	
<p>The Practice is committed to improving the services we provide to our patients. To do this it is vital that we hear from people about their experiences, views and ideas for improving services. By expressing your interest, you will be helping us to plan ways of involving patients that suit you. It will also mean we can keep you informed of opportunities to give your views and up to date with developments within the Practice.</p>	
<p>Yes, I am interested in becoming involved in the Patient Participation Group and would like to be contacted by a representative from the group (please tick)</p>	<input type="checkbox"/>
<p><b>You can opt out at any time, please contact us here at the surgery. This will not affect any other care we provide for you.</b></p>	



**Summary Care Record (SCR)**

The objective of a Summary Care Record is to share key information from your GP records. This enables other NHS services such as A&E or Out of Hours to access your essential health information as and when required. This is particularly beneficial to you in an unplanned or emergency situation.

There are two types of Summary Care Records that can be created:

**a) 'Standard Core' Summary Care Record**

This includes sharing your current and repeat medications, any allergies you suffer from and any harmful reactions to medication you have experienced.

**b) 'Enhanced Core' Summary Care Record**

This includes sharing your 'standard core' records with additional medical information that includes: Your significant illnesses and health problems, operations and vaccinations you have had in the past, how you would like to be treated (such as where you would prefer to receive care), what support you might need and who should be contacted for more information about you.

**We will automatically opt-in all patients to share their Enhanced Core Summary Care Record (option b) unless you choose otherwise.** You are free to change your decision at any time.

Having read the above information regarding my choices I would not like a Summary Care Record (opt-out)

Express dissent for Summary Care Record

I confirm that all details on this form are accurate.

Signature of Patient  ..... Date.....

Or

Signature on behalf of patient:  ..... Date: .....

**For office use only: -  
For registrations**

Birth Certificate  Passport

Patient unable to provide: - Birth Certificate  Passport