Lightwater Surgery

New Patient Registration
Young Person Aged 0-16

We would like to take this opportunity to welcome you to Lightwater Surgery.

Please ensure you have also received a copy of our Practice Information Booklet which gives details of the services we offer. You can also find more information on our website: www.lightwatersurgery.co.uk

Please let one of the receptionists know if you would like to register for EMIS Access which allows patients to book routine appointments and request repeat prescriptions online.

It can take several weeks for your medical records to reach us and we would be grateful if you could complete the enclosed brief questionnaire (one for each family member). This will provide us with some essential information before your medical records arrive with us.

If you have any children **under the age of 5**, please could you kindly complete one of our Health Visitors questionnaires. They can then make contact with you to ensure that the necessary checks and vaccinations can be arranged.

Chk	Reg	Smo	Dia	SCR	Don

Lightwater Surgery

Title	First Name	Surname	Date of Birth
Name of Parents/Guardians			
Home Telephone		Mobile Telephone	
Main Carer		School	
Known Allergies:		Current Medication: *(including inhalers, ointments, creams, tablets and special dietary foods that are on prescription)*	
Family History: Has any first degree relative (parent, brother, sister) ever had the following:			
Heart Attack or Angina	YES / NO	Stroke	YES / NO
Personal Medical History: Has your child ever had any of the following:			
Asthma	YES / NO	Hayfever	YES / NO
Eczema	YES / NO	Diabetes	YES / NO
Please list any long term health problems/operations/hospital treatment:			
Is your child currently receiving care from a specialist?			YES / NO
If Yes, please give details:			
Is your child receiving support from any other services? (eg Social Services)			YES / NO
Is Yes, please give details:			
Please state any concerns you may have about your child's health or behaviour.			
Does your child smoke?		YES / NO / Don't Know	
Please give any other information you feel may be important for us to know about your child's health.			

Immunisations	
Are your child's immunisations up to date?	YES / NO / Don't Know
Children Under 6 years of age – Please could you provide dates of vaccinations given so far.	
1st 5 in 1 Dip/Tet/Polio/Hib/Pertussis	
2nd 5 in 1 Dip/Tet/Polio/Hib/Pertussis	
3rd 5 in 1 Dip/Tet/Polio/Hib/Pertussis	
1st Pneumonia	
2nd Pneumonia	
3rd Pneumonia	
1st Meningitis C	
2nd Meningitis C	
3rd Meningitis C	
1st MMR	
2nd MMR	
Other Vaccinations	

Ethnic Group					
White	British		Asian or Asian British	Indian	
	Irish			Pakistani	
	Other White Background			Bangladeshi	
Mixed	White and Black Caribbean			Other Asian Background	
	White and Black African		Black or Black British	Caribbean	
	White and Asian			African	
	Other Mixed background			Other Black Background	
Not Stated					

Who has Parental Responsibility for this child?	
Name	Relationship to child

Form Completed by	
Date	
Relationship to child	

DATA SHARING OPTIONS

Please complete in BLOCK CAPITALS
If you are filling out this form on behalf of a child, please ensure you fill out their details here:

Title:	Surname:
Forenames:	
Address:	
Postcode:	Phone Number:
Date of Birth:	Signature:

Your details (if different from above)

Your name:	Your signature:
Relationship to patient:	

Summary Care Records (SCRs) enable healthcare professionals working in different care settings to access an electronic summary of key information from a patient's GP record. Currently, SCRs are widely used across NHS urgent and emergency care, such as NHS 111, 999 and Accident & Emergency Departments. However, the SCR may also be used in planned care to provide up to date clinical information.

If you choose to have a Summary Care Record, it will automatically contain important information about any medicines you are taking, any allergies you suffer from and any bad reactions to medicines that you have previously experienced.

You can also choose to add '**enhanced** information' to your Summary Care Record. This will include significant medical history and details about immunisations, your information and / or communication needs and your personal preferences.

Please tick to indicate your Summary Care Record choice:

Patient Consents to sharing the detailed record	
Patient Consents to sharing an **enhanced** record	
Patient DOES NOT wish to share the detailed record	
If you are a Diabetic: Do you consent to Lightwater Surgery sharing your details with the National Diabetes Audit?	Yes / No

Lightwater Surgery would like to be able to contact you, via email and text message, for screening invitations, appointment reminders, letters etc. If you consent to this, please add your personal email address and mobile number here.

Email address:
Mobile phone number:

Signed: ……. Date: ……