Swan and Forest Surgeries

Registration Application (Birth - 5 Years)

Please complete in BLOCK CAPITALS

Full Name: _____ Date of birth: _____

Gender: _____

Home Address:

_____

_____

_____

_____

Postcode: _____

Please ensure your address is within our practice catchment area by using the postcode checker on our website www.swansurgery.org.uk

Country Of Birth:

Ethnicity:

Main Language Spoken at home:

Please tick the statements that apply:

- I live in my own home ☐
- I live in a rented home ☐
- I live in sheltered housing ☐
- I live in a residential home ☐
- I live in a foster home ☐
- I am housebound ☐
- I am a refugee ☐
- I am an asylum seeker ☐

Translator Required? YES ☐ NO ☐

Weight (Kg): _____ Height (cm): _____

Parent / Guardian details

Parent / Guardian One	Parent / Guardian Two
Full Name: _____	Full Name: _____
Contact Number: _____	Contact Number: _____
Relationship to Patient: _____	Relationship to Patient: _____
Email Address: _____	Email Address: _____

Please note that 'Parent / Guardian One' will be listed as the default contact for this child, 'Parent / Guardian Two' will be the secondary contact. Both contacts will be listed as Next of Kin

Vaccination History:

- I have not had any childhood vaccinations yet ☐
- I am up to date with all childhood and routine vaccinations in the United Kingdom ☐
- I was born outside of the United Kingdom and have attached my previous vaccination records ☐

Carers

Do you have a carer? YES ☐ NO ☐

If yes, please provide the name of and relationship to your carer: _____

Are they registered at this surgery? YES ☐ NO ☐

Medical History

Have you ever been diagnosed with any of the following:

- ☐ Asthma
- ☐ Diabetes (DM)
- ☐ Epilepsy
- ☐ Heart Disease (CVD)
- ☐ Hypertension (HTN)
- ☐ COPD
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Cancer
- ☐ Other: _____

Family History

- ☐ Asthma
- ☐ Diabetes (DM)
- ☐ Stroke
- ☐ Heart Disease (<60) (CVD)
- ☐ Hypertension (HTN)
- ☐ COPD
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Breast Cancer
- ☐ Bowel Cancer
- ☐ Other: _____
- ☐ No Relevant Family History
- ☐ Family History Unknown

* Please add relationship to any ticked conditions (i.e. Mother, Father, Grandmother etc.) *

Medications

Do you take any repeat medications? YES ☐ NO ☐

If yes, please speak to a member of the dispensary/prescriptions team to discuss your medication requirements and bring a copy of your repeat medication

What is your Nominated Pharmacy? _____

Please list any drug or other allergies: _____

Please list any religious or lifestyle preferences: _____

Do you need any of the following?:

- ☐ A hearing aid/Loop recorder
- ☐ Lip reading
- ☐ Large print
- ☐ Other: _____
- ☐ Braille
- ☐ British Sign Language
- ☐ Makaton Sign Language

Do you have a Learning Disability? _____

Consent To Hold Your Records

The Practice needs to hold your medical records on the premises in order to give you the best medical care possible. We keep your records on the computer as well as holding your paper notes. All of our patient's medical records are covered by the Data Protection Act 1998. This means that a third party cannot access your records without your written consent. We may use your mobile phone to contact you for appointments reminders and cancellations, health promotions, surgery updates and surveys.

Preferred Method of Contact

Please inform us of your preferred method of contact by circling your choice below:

LETTER EMAIL SMS NO COMMUNICATION

Summary Care Record

Your summary care record is an electronic record of important information about your health and is available to healthcare staff providing your NHS care in England, for example in A&E- This means if you ever become ill and need urgent or out of hours treatment outside of the surgery the clinicians that treat you will have immediate access to important healthcare information about you- The information included in your summary care record is your current medication, allergies you suffer from and any bad reactions to medications you have experienced.

If you do not want this to happen then please ask reception for an Opt Out Form

Please ensure you have answered all parts of this questionnaire as accurately as possible and return your completed forms to Reception, where it will usually be processed within 5 working days. If parts of your application are missing, your application may be delayed.

Please note, you will need to provide your Photo ID and the child's Birth Certificate, Adoption certificate or Red Book when returning your forms to Reception

Parent / Guardian SIGNATURE _____

DATE _____

NHS Summary Care Record with additional information

If you are registered with a GP practice in England you will have a Summary Care Record (SCR), unless you have previously chosen not to have one. It includes important information about your health:

- Medicines you are taking
- Allergies you suffer from
- Any bad reactions to medicines

You may need to be treated by health and care professionals that do not know your medical history. Essential details about your healthcare can be difficult to remember, particularly when you are unwell or have complex care needs. Having an SCR means that when you need healthcare you can be helped to recall vital information.

SCRs can help the staff involved in your care make better and safer decisions about how best to treat you.

You can choose to have additional information included in your SCR, which can enhance the care you receive. This information includes:

- Your 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
- Who should be contacted for more information about you

What to do next

If you would like this information adding to your SCR, then please complete this form, for return to the relevant GP surgery.

Name of Patient: .....

Date of Birth: ..... Patient's Postcode: .....

Surgery Name: ..... Surgery Location (Town): .....

NHS Number (if known): .....

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

If you are filling out this form on behalf of another person, please ensure that you fill out their details above; **you** sign the form above and provide your details below:

Name: .....

Capacity: circle as appropriate Parent Legal Guardian Lasting Power of Attorney

If you require any more information, please visit **https://digital.nhs.uk** or phone NHS Digital on **0300 303 5678** or speak to your GP Practice