Woodhill Surgery
Station Road
Mayfield
TN20 6BW
Tel: 01435 873000
Email: hwccg.woodhill@nhs.net

UNDER 13 REGISTRATION PACK

PLEASE NOTE THAT ALL PAGES IN THIS PACK NEED TO BE COMPLETED

Thank you for your request to join Woodhill Surgery**. Please note to register your child/children you will need to bring in a copy of their Birth Certificate or Passport.**

Please complete this form in full so that the doctor will have important background information whilst your medical records are in transit as it can take several months for your records to reach us.

(For confidentiality purposes mobile numbers, email addresses and online services are deleted from a child's medical records from the age of 13 years).

For Reception use only

Identity verified by (initials)	Date	Copy of Birth Certificate ☐ Or Copy of Passport ☐

If you require this document to be printed in large text, please contact 01435 873000

NEW PATIENT QUESTIONNAIRE

Please complete this questionnaire in full so that the doctor will have important background information whilst your medical records are in transit as it can take several months for your records to reach us.

Have you ever been registered at this surgery before: YES/NO

Please complete in BLOCK CAPITALS

Forename ………………………………………………… Surname …………………………………………………………………

Preferred Name ………………………………………………………….

Date of Birth ……………………………………… [ ] Male [ ] Female

Parents information/Guardian/Next of Kin

Mother's Name …….

Address …….

………

Home Telephone number: ……………………………………………………………
I give explicit consent to contact me regarding my child by telephone ( )

Mobile Telephone number: ………………………………………………………
I give explicit consent to contact me regarding my child by mobile ( )

Email Address …………………………………………………………………………………
I give explicit consent to contact me regarding my child by email ( )

Preferred Contact Method: (please tick) ( ) EMAIL ( ) TEXT ( ) LETTER

Father's Name ……………………………………………………

Address ……………………………………………………………………………………………………

………

Home Telephone Number: ……………………………………………………
I give explicit consent to contact me regarding my child by telephone ( )

Mobile Number ……………………………………………………
I give explicit consent to contact me regarding my child by mobile ( )

Email Address ……………………………………………………………………
I give explicit consent to contact me regarding my child by email ( )

Ethnic Origin (please tick):

	African		Other Asian Background
	Bangladesh / British Bangladesh		Other Mixed Background
	White British / Mixed British		Other White Background
	Caribbean		Other
	Chinese		Pakistani / British Pakistani
	Ethnic Category not stated		White and Asian
	Indian / British Indian		White and Black African
	Irish		White and Black Caribbean

Specific Needs:

Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action.

Are you hard of hearing?	
Are you visually impaired?	
Please state any learning disabilities you have	
Please state any requirements you have to be able to access the Practice premises.	
Do you require the help of a Translator/Interpreter?	
Main language spoken?	

MEDICAL HISTORY

Please indicate your current: **Height:** **Weight:**

Have you ever had any surgical operations?: YES/NO
If yes please give details and approximate dates

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Have you ever had to stay in hospital for any other reason?: YES/NO
If yes please give details and approximate dates

……

Are you presently undergoing hospital treatment?: YES/NO
If yes, name of hospital and consultant if known, and for what reason:

……

……

Are you taking any prescribed medication?: YES/NO
If yes please list them with strengths/dosages if known.
Please book an appointment to set up any routine medications with the doctor as soon as you are registered at the surgery.

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Are you regularly taking any non-prescription medication?: YES/NO
If yes please list them

……

……

Have you any significant allergies: YES/NO
If yes please list
……

……

Have you ever suffered from any of the following (please tick)

Diabetes		Heart Disease (type if known)	
Cancer (site if known)		Hypertension	
Asthma		Other Chest Disease	
Hepatitis/Jaundice		Severe Indigestion/peptic ulcer	

Family History: Does any member of your family have any of the following conditions?

Condition	Relationship	Age at Diagnosis
Heart Problems?		
Stroke/CVA?		
High Blood Pressure?		
Asthma?		
High Cholesterol?		
Epilepsy?		
Cancer? (site if known) eg stomach		
Glaucoma?		
Diabetes?		

Immunisation History:

The doctors at this practice recommend that all children are fully immunised unless there are medical reasons to do otherwise.

Please indicate list below of all immunisations given with dates if known.

Immunisation Given	Date Given

systmonline
BOOK REQUEST REGISTER

Patient Online Registration Form

PERMISSION FOR PARENTS/GUARDIANS TO ACCESS ONLINE SERVICES UP TO THE AGE OF 13

CHILDS NAME ………………………………………………………………………… **DOB**…………………………………..

ADDRESS: …….

HOME TEL NO: ……………………………………………………….. MOBILE NO…………………………………………….

PLEASE PROVIDE A COPY OF YOUR CHILDS BIRTH CERTIFICATE & COMPLETE NEXT OF KIN DETAILS BELOW:-

MOTHERS NAME ………………………………………………………………………… DOB …………………………………..

ADDRESS ……..

HOME TEL NO …………………………………………………………… MOBILE NO …………………………………………….

EMAIL ADDRESS ……………………………………………………….. SIGNATURE …………………………………………….

FATHERS NAME ………………………………………………………………………… DOB ……………………………………..

ADDRESS …….

HOME TEL NO ………………………………………………………….. MOBILE NO. …………………………………………….

EMAIL ADDRESS ……………………………………………………….. SIGNATURE …………………………………………….

PLEASE NOTE PARENT MUST BE REGISTERED FOR ONLINE SERVICES AT WOODHILL SURGERY TO HAVE PROXY ACCESS.

ACCESS TO YOUR CHILDS ONLINE SERVICES WILL BE REMOVED AS HE/SHE REACHES THE AGE OF 13 & ALL MOBILE NUMBERS AND EMAIL ADDRESSES WILL BE DELETED IN ACCORDANCE WITH OUR CONFIDENTIALITY POLICY.

Information for new patients: about your **Summary Care Record**

NHS Digital

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 who 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 a Summary Care Record means that when you need healthcare you can be helped to recall vital information.

SCRs can help the staff involved in your care can help 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.

Name ……………………………………………………………………………………….

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

NHS Number (if known) ……………………………………………….

Signature ………………………………………………………………… Date …………………………………………………

If you are filling 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://digial.nhs.uk or phone NHS Digital on 0300 303 5678 or speak to your GP

For GP practice use only:

To update the patient's consent status, use the SCR consent preference dialogue box and select the relevant option or add the appropriate read code from the options below.

Summary Care Record consent preference	CTV3
The patient wants a core Summary Care Record (express consent for medication, allergies and adverse reactions only)	XaXbY
The patient wants a Summary Care Record with core and additional information (express consent for medication, allergies, adverse reactions and additional information)	XaXbZ
The patient does not want to have a Summary Care Record (express dissent for Summary Care Record – opt out)	XaXj6