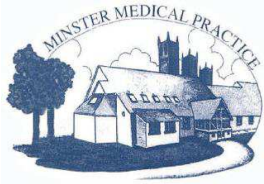

MINSTER MEDICAL PRACTICE

Dr Jonathan Gibbs, Dr Christopher Batty, Dr Paul Fitzgerald, Dr Julia Brewin, Dr Sarah Culpitt
Practice Manager – Jo Downes
www.minstermedicalpractice.co.uk
Tel: 01522 515797

NEW PATIENT REGISTRATION FORM – UNDER 16 YEARS

Welcome to Minster Medical Practice. Please help the Doctors by completing this questionnaire as fully and accurately as possible.

PATIENT DETAILS Date ___________________

Mr Mrs Miss Ms Other		Surname:	
Date of Birth:	/ /	First Names:	
NHS No:		Previous name/s:	
Home Address:			
Home Tel No:		Mobile Tel No:	
Preferred No:	Home ☐ Mobile ☐ Other:		
First language:		Country of birth:	
Ethnicity: (please tick the most appropriate box)	British or Mixed British	Irish	
	Indian or British Indian	Chinese	
	Pakistani or British Pakistani	Caribbean	
	Bangladeshi or British Bangladeshi	African	
	White & Black Caribbean	Other Black background	
	White & Black African	Other White background	
	White & Asian	Other Asian Background	
	Ethnic category withheld	Other mixed background	
Height:		Weight:	

PARENTAL RESPONSIBILITY

Please list all persons who have parental responsibility (mother/father/guardian) and anyone who may bring the patient to appointments on behalf of the parent/s. Please include their relationship to the patient

Name:	
Relationship to patient:	
Name:	
Relationship to patient:	
Name:	
Relationship to patient:	

FAMILY MEDICAL HISTORY

Has the patient's parent(s) or sibling(s) suffered from any of the problems listed below – please circle the family member and write the age at which they were diagnosed:

Asthma	Father / Mother / Sister / Brother	Age:
Blood Pressure	Father / Mother / Sister / Brother	Age:
Cancer	Father / Mother / Sister / Brother	Age:
Diabetes	Father / Mother / Sister / Brother	Age:
Heart Attack	Father / Mother / Sister / Brother	Age:
Stroke	Father / Mother / Sister / Brother	Age:

MEDICAL HISTORY - Please tick if your child has a history of any of the following:

Cancer		Depression or Mental health problems	
Dementia or Alzheimers		Kidney Disease	
Hypertension (high blood pressure)		Heart Failure, Coronary Heart Disease or Atrial Fibrillation	
Asthma or COPD		Learning Difficulties	
Diabetes		Thyroid Disease	
Epilepsy		Stroke or Transient Ischemic Attacks	
If they have any other history, important illnesses or disabilities not mentioned above please give details here (include special diet requirements):			

ALLERGIES

Please list any allergies the patient has:	

MEDICATION

REPEAT MEDICATION: If your child is currently taking any repeat medication, please list it below. You will need to book a review appointment with a GP to re-start your medication. Please make sure the child has have enough supply to last for a month.

PHARMACIES – Please tick where you would like to collect your repeat prescriptions from:

Co-op Cabourne		Co-op Burton Road	
Co-op St. Botolphs (South Park)		Co-op Winning post (Monks Rd)	
Boots High Street		Boots Carlton Centre	
Tesco		Watsons	
Lloyds		Other	
Collect from Minster Medical Practice			

SMS/EMAIL CONSENT - On occasion we may wish to contact you via text message or email, for example to send confirmation of appointment date and time or for health related messages.

I **GIVE** consent for Minster Medical Practice to contact me via text message or email.	
Signature:	Date:
I **DO NOT GIVE** consent for Minster Medical Practice to contact me via text message or email.	
Signature:	Date:

Please remember to update the Practice if you change your telephone number or email address.

NHS PATIENT INFORMATION SHARING – Please find enclosed leaflets for Summary Care Record and Electronic Patient Record Sharing IN and OUT. Please read these fully.

I **CHOOSE** to have a NHS Summary Care Record	
Signature:	Date:
I **DO NOT CHOOSE** to have a NHS Summary Care Record	
Signature:	Date:

I **GIVE** consent for Minster Medical Practice to **SHARE IN** my electronic patient record	
Signature:	Date:
I **DO NOT GIVE** consent for Minster Medical Practice to **SHARE IN** my electronic patient record	
Signature:	Date:

I **GIVE** consent for Minster Medical Practice to **SHARE OUT** my electronic patient record	
Signature:	Date:
I **DO NOT GIVE** consent for Minster Medical Practice to **SHARE OUT** my electronic patient record	
Signature:	Date:

ADDITIONAL COMMUNICATION REQUIREMENTS – Does your child have any specific communication needs? By leaving this section blank we **will not** record alternative communication methods in your record. Please tick the boxes that apply.

Braille Grade 1		Braille Grade 2	
British Sign Language		Contact via carer/third party	
Verbally (telephone) only		Email only	
Text message only		Large print font	
Interpreter	(please state language)		
Other	(please state other)		

YOUR DETAILS –where this form has not been completed by the patient please provide details below:

Name of person completing form:	
Relationship to patient:	
Signature:	
Date:	

CARERS QUESTIONNAIRE

Who is a carer? A carer is someone, who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to being elderly, physical or mental illness, addiction or disability.

We would be grateful if you could complete the following questions for the practices Carer's Register. The register enables the practice to proactively manage carer's needs with the practice and to consider the provision of services to carers. The practice will also ensure that all patients who are carers are informed and supported in joining the local carer's link.

IF YOU ARE A CARER

Details of the person(s) you are caring for	
Title	
Surname	
Forename	
Date of Birth	
Address	
Postcode	
Telephone number	
Relationship to patient	

IF YOU ARE BEING CARED FOR

Details of your carer	
Title	
Surname	
Forename	
Date of Birth	
Address	
Postcode	
Telephone number	
Relationship to carer	

Patient checklist for completing the registration form:

NHS Number (can be obtained from previous GP Practice) ☐

Contact details (address, telephone number and email) ☐

Previous GP details ☐

Proof of address ☐

Photo ID ☐

Return forms to the Practice with proof of address and ID ☐

Practice checklist when form returned by patient:

Photo ID ☐

Proof of Address ☐

Address within our catchment area ☐

Telephone numbers ☐

NHS Number ☐

Town and Country of birth ☐

Previous GP ☐

Full previous address ☐

SMS consent ☐

Summary Care Record consent ☐

Sharing in and out preferences ☐

New patient health check ☐

Smoking and alcohol status ☐

Checked by …………………………………………. Date……………………..