

Stockbridge Surgery, New Street, Stockbridge, Hants. SO20 6HG

Dr Natalie Avery

Dr Edward Gibbons

Dr Claire Walsh

Dr Bridget Pemberton

Dr William Dougal

Dr Julia Snyder

Dr Helen Prince

Dr Hannah Pike

Dr Emily Kerton

Welcome to the Practice

It often takes many weeks before your records arrive from your previous GP. To help us until then, please fill in this form as completely as you can.

If you would like to register for Online services, which include the ability to book an appointment or order repeat prescriptions online, please sign up to the NHS App. For more information regarding online services please visit our website and click the services tab and then select online access.

Do you have any special communication needs? 🞏 Yes 🞏 No

If yes: 🞏 Sign Language 🞏 Large Print 🞏 Other …………………….

**CONFIDENTIAL MEDICAL REGISTRATION FORM (CHILDREN UNDER 16)**

**Please complete all pages in FULL using BLOCK capitals**

Surname

First Names (in full)

Previous Surnames

**Title**: 🞏 Mr 🞏 Mrs 🞏 Miss 🞏 Ms 🞏 Male 🞏 Female

Date of Birth (day/month/year) NHS Number 🞏🞏🞏 🞏🞏🞏 🞏🞏🞏🞏

 (if known)

Town & country of Birth

 Post Code:

Address

Telephone number: Mobile number:

Email address:

**Please help us trace your previous medical records by providing the following information:**

Your previous address in UK

 Post Code:

Name of previous Doctor

while at that address

 Post Code:

Address of previous Doctor

**If you are from abroad:**

Your first UK address where

 Post Code:

Registered with a GP

If previously resident in UK Date you first

date of leaving came to UK

**If registering a child under 5:**

* I wish the child above to be registered with Stockbridge Practice for Child Health Survelliance

**If you need your doctor to dispense medicines & appliances\*:**

For Dispensing Practices only:

* I live more than 1 mile in a straight line from the nearest chemist

**Personal Medical History…..**

Type of Birth:

*(eg normal, forceps, Caesarean*

*If under 5)*

Birth Weight: Feeding:

*(If under 5) (Breast or bottlefed*

 *If under 5)*

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

|  |  |  |
| --- | --- | --- |
| **Condition** | **Year diagnosed** | **Ongoing**  |
|  |  | Yes/No |
|  |  | Yes/No |
|  |  | Yes/No |

**Family History…..**

Have any close relatives (*father, mother, sister, brother only*) ever suffered from: (please indicate who in the boxes)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Heart attack | Stroke | Diabetes | High Blood Pressure | Asthma | Glaucoma | Cancer |
|  |  |  |  |  |  |  |

**Immunisations ……**

Please provide details of your childs immunisations with dates if possible (under 5’s). If possible please give your Red Book to Reception to photocopy:

|  |  |  |  |
| --- | --- | --- | --- |
| **Immunsation** | **Date** | **Immunisation** | **Date** |
| Tetanus |  | Booster: Tetanus |  |
| Whooping Cough |  | Booster: Diphtheria |  |
| Polio |  | Booster: Polio |  |
| HiB |  | Booster: MMR |  |
| Measles |  |  |  |
| MMR |  |  |  |
| BCG (TB) |  |  |  |
| Meningitis |  |  |  |

**List of current medication ……**

|  |  |
| --- | --- |
| **Name of medication**  | **Dosage** |
|  |  |
|  |  |

**Allergies ……**

Please list any allergies you have to any drugs/medication:

|  |  |
| --- | --- |
| **Name of medication** | **What was the problem or upset?** |
|  |  |
|  |  |

**Ethnicity ……**

**vej**

🞏 British or mixed British 🞏 Irish 🞏 African 🞏 Caribbean 🞏 Indian 🞏 Pakistani

🞏 Bangladeshi 🞏 Chinese 🞏 Other (please state):

🞏 Decline to state

**Next of kin ……**

**vej**

Name: Tel. contact

 number:

Relationship:

**Data Sharing Consent Choices ……**

**vej**

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations.

If you wish to **OPT OUT** please read carefully the accompanying leaflet on Data Sharing which explains the new legislation.

Where you have provided information on how to contact you, can you confirm you are happy for us to contact you by the following:

By email/text 🞏 Yes 🞏 No This will be to send you letters, newsletter and

 the like

By email/text 🞏 Yes 🞏 No This will be to send you reminders of

appointments via text and other direct health care information relating to you

**Signature ……**

**vej**

I confirm that the information that has been provided is true to the best of my knowledge.

Signed: Date:

Signature on behalf of patient 🞏 Signature of patient 🞏

|  |
| --- |
| Staff use only |
| I.D Checked by | Date |
|  |  |

**03/02/16**