# The Harbour Medical Practice

**1 Pacific Drive, Sovereign Harbour North, Eastbourne, East Sussex, BN23 6DW**
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# New Patient Registration (Child)

## About you

Surname: …… Forename(s): ……

Date of Birth (dd/mm/yyyy): ……...

Gender: ……

## Contact Information

Address:……..

Postcode…….

Telephone: …… Mobile: ……

Email: ……

Please tick below your preferred choice of contact:

**Text** ☐ **Phone** ☐ **Email** ☐ **Post** ☐

Previous GP name and address……

## Service Families and Military Veterans

As a practice, we fully support the Armed Forces Covenant. We can only do this if we know our patients connections to the Armed Forces. Please tick the below boxes that apply to you:

| | | | |
|---|---|---|---|
| **I AM** a Military Veteran | | **I AM** currently serving in the Reserve Forces | |
| **I AM** married/civil partnership to a serving member of the Regular/Reserve Armed Forces | | **I AM** married/civil partnership to a Military Veteran | |
| **I AM** under 18 and my parent(s) are serving member(s) of the armed forces. | | **I AM** under 18 and my parent(s) are veteran(s) of the armed forces. | |

## Ethnicity

Having information about patients' ethnic groups would be helpful for the NHS so that it can plan and provide culturally appropriate and better services to meet patients' needs.

If you do not wish to provide this information you do not have to do so.

Please indicate your ethnic origin by ticking the below box:

| | | | |
|---|---|---|---|
| British or mixed British | | Pakistani | |
| Irish | | Bangladeshi | |
| African | | Chinese | |
| Caribbean | | Other (Please state) | |
| Indian | | | |

## Country of birth

In which country were you born?.....

**If you have not registered with the NHS please state the date you first entered the UK.....**

## Next of kin

Surname: ..... Forename(s): .....

Gender: ..... Relationship to you:.....

## Next of kin contact information

Address: .....

Mobile: .....

## Contacting you

**We will use your contact details to send reminders about appointments, reviews and other services which may be of benefit in your medical care**

Do you consent to the Surgery sending letters to your home address? **Yes** ☐ **No** ☐

Do you consent to the Surgery sending text messages to your mobile? **Yes** ☐ **No** ☐

Do you consent to the Surgery sending messages to you by email? **Yes** ☐ **No** ☐

Do you consent to the Surgery leaving messages on your phone? **Yes** ☐ **No** ☐

(We will not leave detailed messages on your phone, but may ask you to contact us or leave a simple message if we do not need to speak to you).

## Summary Care Record

Summary Care Record (SCR)
If you decide to have a SCR, it will contain important information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines that you have had it will also include basic information about your current diagnoses. Giving healthcare staff access to this information can prevent mistakes being made when caring for you in an emergency or when your GP practice is closed. Your Summary Care Record will also include your name, address, date of birth and your unique NHS Number to help identify you correctly. If you and your GP decide to include more information it can be added, but only with your express permission.

**For more information**: Phone 0300 123 3020 or visit www.nhscarerecords.nhs.uk

I do not wish to have a Summary care Record (N.B. this will mean NHS Healthcare staff caring for you may not be aware of your current medications, any allergies or reactions to previous medication.)

**I wish to opt out of SCR** ☐

## Electronic Prescribing Service (EPS)

The EPS allows prescribers – such as GPs and practice nurses to send prescriptions electronically to a dispenser (such as a pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. The NHS aim that by 2020 they will hopefully be paper free or a paper-lite service. To help achieve this The As a practice, we would encourage all patients to opt for electronic prescribing.

☐ **I DO** give consent for my prescriptions to be sent electronically to the pharmacy

☐ **I DO NOT** give consent for my prescriptions to be sent electronically to the pharmacy

**Nominated pharmacy** ……

**Disabilities / Accessible Information Standards**

**As a practice we want to make sure that we give you information that is clear to you. For that reason we would like to know if you have any communication needs.**

Do you have any special communication needs?

**Yes** ☐ **No** ☐

**If yes,** please state your needs below:

**.....**

**.....**

**.....**

Do you have significant mobility issues? **Yes** ☐ **No** ☐

Are you blind/partially sighted? **Yes** ☐ **No** ☐

Do you have significant problems with your hearing? **Yes** ☐ **No** ☐

Have you yourself ever suffered from any important medical illness, operation or admission to hospital? **If so** please enter details below:

| **Condition** | **Year diagnosed** | **Ongoing?** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Allergies**

Please list any drug or food allergies that you have:

.....

.....

**Medications**

Please provide a list of repeat medications:

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……

……

……

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**Form completed by**

Name……

Relationship to patient ……

Date……..