CHILD'S REGISTRATIONS

Belsize Priory Medical Practice
208 Belsize Road
London NW6 4DX
0207 328 8200
E-mail: reception.bpmp@nhs.net
www.belsizepriorymedicalpractice.co.uk

PLEASE NOTE ALL REGISTRATIONS ARE DONE BETWEEN 2:00-6:00PM

(except Wednesday)

We are unable to register you outside these hours as we need to give priority to existing patients.

When registering this is what we require from you:

→ **Full Birth Certificate**

→ Carers Passport/ Driving Licence (proof of your identification)
If baby/child has a birth certificate please also bring this in as proof.
→ 2 proofs of carers address to go along side baby/child's

→ **Child's RED BOOK (Immunisation Records) for age 6 weeks - 6Years Old**

→ **NHS NUMBER –** Without this we will not be able to register you.

ZERO TOLERANCE

The practice pledges to treat all patients with dignity and respect.
Our staff have the right to be treated with dignity and respect in the same way.
We will NOT tolerate violence in any form, physical or verbal towards our Staff.

APPOINTMENT BOOKING ONLINE

You can book and cancel your appointment, request prescription and update your address ONLINE via The Practice website: www.belsizepriorymedicalpractice.co.uk.

Please request your PIN Number from the Receptionist during your Registration.

Office use only:	2 Proofs of Address □ Leaflet given □
	Carers ID □ Red book □
Checked by _____ Registered by _____ Date: _____ EMIS NUMBER:	

NEW PATIENT'S HEALTH QUESTIONNAIRE (CHILD'S)

Surname's	
First Name's	
Date and place of birth	
Home Address	
Telephone number	

1. Ethnic Category:

WHITE:		**MIXED**		**Asian & Asian British**	
British	□	White & Black Caribbean	□	Indian	□
Irish	□	White & Black African	□	Pakistani	□
Other	□	White & Asian	□	Bangladeshi	□

BLACK/BLACK BRITISH:		**OTHER:**	
Caribbean	□	Chinese	□
African	□	Other	□
Other	□	Not Stated	□

Country of Origin: _____ **Main Language:** _____

Jehovah witness YES □ No □ **Interpreter:** Needed □ Not Needed □

2. Carer of Patient **a.) Name** _____

b.) Telephone Number: _____

3.. Child's Day Care: _____

4. If your child has any disabilities, please give us details: _____

5. Does anybody in the child's family suffer from any of the listed disease.

Disease	**Relationship To You**
Cancer	
Stroke	
Asthma	
Heart Disease	
Diabetes	
Epilepsy	
High Blood Pressure	
Thyroid Disorder	
Mental Problem	
Bronchitis, Emphysema	

Eczema	

6. Please Give us the Name & Address of your Childs School:

Name & Address of School	
School Telephone Number	

7. Child immunisation update, if child has had any of these vaccines

Please complete the following:

Vaccinations	**Place Of Procedure**	**Date**
1st DTP & Polio Vac/HIB (2 month old)		
1st Pneumococcal (PCV) (2 month old)		
2nd DTP/PV/HIB (3 month old)		
1st Meningitis C Vac. (3 month old)		
3rd DTP & Polio Vac/ HIB (4 month old)		
2nd Meningitis C Vac. (4 month old)		
2nd Pneumococcal (PCV) (4 month old)		
HIB/ Meningitis C Vac (around12 month)		
1st Measles/Mumps/Rubella Vac (MMR) (around13month)		
3rd Pneumococcal (PCV) (around 13 month)		
4th DTP/PV/HIB Booster (3-4 years)		
2nd Measles/Mumps/Rubella Vac (MMR) Preschool boost		
(3-4 years)		

Is the Child allergic to anything? Yes □ No □ **If yes please specify:**_____

8. Please state name of parent/guardian on the birth certificate.

Name:	
Relationship To Patient:	
Email address	
Appointment online	**YES** **NO**
Telephone Number:	

9. Please complete:

Patient's Name: PRINT	
Patient parent/guardian Signature:	
Today's Date:	

To be completed if you have specific communication needs

Communication Support

If you struggle to complete this form, please ask a member of staff to help you.

Do you consent for this information to be shared with other health & social care organisations?
Yes [ ] No [ ]

Do you need an interpreter? Yes [ ] No [ ] Language:……

Are you visual Impaired? Yes [ ] No [ ]
Would you benefit from any of the following: Braille [ ] Large Print [ ] Audio tape [ ]
(please note that our system don't allow this at present, however, capturing the information will help us plan future developments)

Deafness: Yes [ ] No [ ]
Other……

If you have a difficulty communicating, which is your preferred method of communication.

Home tel number	[ ]	letter to home address	[ ]
Work tel number	[ ]	letter to temporary address	[ ]
Mobile tel number	[ ]	Fax	[ ]
Email address	[ ]	video conference*	[ ]

(*please note that our system don't allow this at present, however, capturing the information will help us plan future developments)

Do you have any other communication need we should know about? Please Describe?

Carer Information
(i) Are you a carer for someone? (Y/N) If yes, are they registered at this practice? (Y/N)

Name of the person you care for……Their contact number……

(ii) Do you have a carer? (Y/N) If yes, are they registered at this practice? (Y/N)

Name of the person you care for……Their contact number……

Name……

Date of Birth:……/……/……

Please note: The information you give will be treated confidentially and is subject to the Data Protection Act.

DATA SHARING

Please read and make your selection by ticking the box or boxes next to the right statment please fill out the required information below, sign and date the form and return it to reception.

Recording Consent of New Patients for Data Sharing Initiatives in Camden		
Camden Integrated Digital Record Local Initiative	Camden Integrated Digital Record (CIDR), enables your Camden care providers, when they are treating you, to view the relevant information about the care you receive, and so give you the best possible care. **PLEASE READ ATTACHED INFO**	I want to: Opt in to CIDR. ☐ Opt out of CIDR. ☐ **IF YOU OPT OUT YOU MUST COMPLETE THE OPT OUT FORM ATTACHED.** **ADMIN- do not code opt put.**
Summary Care Record National Initiative	If you have a Summary Care Record your health care providers can view your medication, bad reactions to medications and allergy information when treating you in an emergency or when your practice is closed.	I want to have a Summary Care Record. ☐ I do **not** want to have a Summary Care Record. ☐

Name: .....

Date of Birth: .....

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