The Bridge Surgery, 8 Evesham Road, Headless Cross, Redditch, B97 4LA
01527 555600

New Patient Registration Pack (Under 16's) – Bridge Surgery 2019

New Patient Information

We can Only register a child under the age of 16 years of age with the surgery if a parent or guardian of the same address is also registered/registering here with the practice.

We do not require proof of identification or address for someone under 16 years old however for children under 5years of age we ask you to present with their red book health record on returning there registration pack

Information for New Patients.

We're improving how we communicate with patients.
Please tell us if you need information in a different format or need communication support.

OPENING TIMES

MONDAY – FRIDAY:

8:30AM – 1:00PM

1:00pm – 2:00pm - Closed

2:00PM – 6:30PM

PHONE LINES

Our phone lines open at 8.30am - 1.00pm and 2.00pm - 5.30pm

CONSULTING TIMES

Appointments with GPs and Nursing Staff are available

09:00 am - 12:00 pm and 3:00 pm - 5:30pm Monday to Friday

EXTENDED HOURS

*** Late evening appointments are available on Mondays and Wednesdays between 18:30 and 19:30. These appointments are Available but are subject to meeting certain criteria**

WE ARE HERE FOR YOU FOR LONGER

Across Redditch and Bromsgrove General Practices are working together to provide further appointments with GPs and Nurses on evenings and weekends . These can be accessed via the HUB and booked through your usual practice. The Extended Access HUB is currently held at a central location and this will be St Stephens Surgery in Redditch. We will hold at least one extended access clinic each month for further details please ask at reception.

As part of the Extended Access Hub we are now also offering an early morning bloods clinic held a St Stephens Surgery this will be held one day a week, subject to change for further information and to book you early morning blood test please ask at reception.

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Title	
Surname	
Forename	
Middle Name(s)	
Date of Birth	
NHS Number	
Gender	
Previous Surname(s) (where applicable)	
Town & Country of Birth	
Ethnicity	**In order that we may take into account a patient's culture, religion and background when providing appropriate individual care, your assistance in completing this section is greatly appreciated as it helps us to improve our policies and practices.. Please Circle appropriate** White British — Pakistani White Irish — Bangladeshi White Other — Other Asian background White & Black Caribbean — Black Caribbean White & Black African — Black African White & Asian — Other Black background Other Mixed background — Chinese Indian — Any Other
Main Language	
Interpreter Required?	Yes ☐ No ☐

HOME ADDRESS:	
House Name\Flat Number	
Number & Street	
Locality	
Town	
County	
Postcode	
CONTACT DETAILS:	
Home Telephone	
Mobile Telephone	
Email Address	
PATIENT CONTACTS:	
Next of Kin/Parental Responsibility	(where appropriate list all contacts who have parental responsibility)
Relationship	
Telephone Number	

Children Under 5years of ages

Type of birth (e.g. natural,Caesarean)	
Birth weight (if known)	
Feeding (e.g. breast or bottle)	

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PLEASE HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING:

Previous address in the UK	
Name & Address of previous GP	

IF YOU ARE FROM ABROAD:

Your first UK address where registered with a GP	
If previously resident in UK; date of leaving	
Date you arrived in the UK:	

Please note all details of children under 5 are passed to the Health Visiting Team for Child Health Surveillance

HEALTH INFORMATION:

☐	Heart disease/Angina	High Blood Pressure	☐
☐	Asthma	COPD	☐
☐	Diabetes	Epilepsy	☐
☐	Stroke/TIA	Cancer	☐
☐	Hypo/Hyperthyroidism	Dementia	☐
☐	Rheumatoid Arthritis	Osteoporosis	☐
☐	High Cholesterol	Other	☐

If Other Please Specify :

Do You have any Allergies? (e.g Antibiotics/Foods/Bee Stings/Latex)
YES ☐ NO ☐

If YES Please Specify :

If you Have a Family History of any of the above Conditions Please State including which Relative:

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details: (please continue on separate sheet if needed)

Condition	Year Diagnosed	Ongoing?
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

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Does your child have any allergies?(e.g. antibiotics, food, bee sting, latex,)	YES ☐	NO ☐
If Yes please state:		

Immunisations; If known, please circle the immunisation received and complete the date received;			
	Date Received:		Date Received:
Whooping Cough		Polio	
Tetanus		HiB	
Measles		MMR	
BCG (TB)		Meningitis	
Booster: Tetanus		Booster: Polio	
Booster: Diptheria		Booster: MMR	

Weight (if known) (st\lbs or Kgs)		Height (if known) (ft\" or metres)	
Please List any current medications or If you have a repeat medication slip from your previous GP please attach to this form:			

Identifying Young Carers, Does your child look after a relative that is unable to care for themselves due to a physical, mental impairment or age?

YES ☐ NO ☐

If so, we would like to support you and ask that you please complete the following:

Name of the person you are Caring for:

Address :

Identifying Patients with Disabilities and other needs - Are you:

☐ registered blind partially sighted

☐ registered deaf registered deaf/blind

☐ on the learning disabilities register

☐ have a visual impairment

☐ have hearing difficulties

☐ have a hearing aids

Do you have any information or communication needs when attending the surgery or receiving calls and letters from us?

Are you happy for these requirements to be shared with other healthcare professionals?

Yes ☐ No ☐

Electronic Prescription Service: The practice can now send your prescription to your preferred pharmacy electronically. If you have previously nominated a pharmacy in another area and you now wish to change to a local pharmacy, please inform us of your preferred pharmacy:	

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Please Advise the Practice of Your Communication Preferences:

Please note that unless we are informed otherwise the contact numbers and communication preferences provided on this form will remain on the listed patient's record after they turn 16. Therefore we advise that the records are updated after the Childs 16th birthday to provide full confidentiality.
I Would like to receive reminders for my appointments via SMS Text ☐
I Do Not wish to receive reminders for my appointments via SMS Text ☐

IMPORTANT INFORMATION: Your named GP will be allocated via your surname but you are able to book appointments with any of the GP's. A – G will be Dr Caranci H – M will be Dr Franklin N – Z will be Dr Tayara	
Name of person signing on behalf of Patient:	
Relationship to Patient:	
Signed:	
Date:	
Should you require any further information about the Practice please refer to the Practice Website: www.thebridgesurgery.co.uk or speak to Reception.	
If you required any further information about how we use your medical records and information on Practice Fair processing and Privacy Notice please refer to our website http://www.thebridgesurgery.co.uk or speak to Reception	
RECEPTION ONLY:	
Seen by (Name):	
Red book Seen by (Name) :	
Date :	