**CHILDREN REGISTRATION FORM – (under 16 years old)**

**To register a child, we require evidence of the identity of those registering the child and their relationship to the child. We also require child’s birth certificate and for children under 5 years old we need a copy of red immunisation book.**

**Please return fully completed forms to the Practice *in person*. Monday – Friday between 8.30am – 6.30pm .Please note during busy times you may have to wait, as the telephone’s take priority.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Details:**

**Surname:**….…………………………… **First Name:** ……………………………..

**Gender:** Male / Female **Age:** ………… **Place of Birth:** ………………………………

**Home Address including Post Code:** ………………………………….…………………….

…………………………………………………………………………………………………

**Mobile Number:** ………………………………… **Home Number:** ………………………

**Email Address:**………………................................................................................................

**School (if applicable**)………………………………………………………………………………..

**Main language spoken:**……………………… **Interpreter needed: Yes No**

**Text Message Appointment Reminders**:

Do you want to use the SMS text message service? Yes No

**Ethnic Monitoring**

Please tick which ethnic group best describes your background?

 **White Asian or Mixed Black**

 **Asian British**

* British 🞏 Indian 🞏 Black Caribbean & White 🞏 Caribbean
* Irish 🞏 Pakistani 🞏 Black African & White 🞏 African
* Other White 🞏 Other Asian 🞏 Other Mixed 🞏 Other Black

**Parent/Guardian Contact Details:**

This helps to make sure the right people appear in the correct household on our computer system.

Mother’s Details

Surname:………………………… First Name:……………………Date of Birth………......

Address:………………………………………………………………………………………

Email:…………………….………......................Contact number……………………………

Father’s Details

Surname:…………………………… First Name: …………………Date of Birth…………

Address:……………………………………………………………………………………

Email:…………………….………............................Contact number……………………

Guardian’s Name: ………………………………………Relationship: ................................

Telephone Number(s): ………………………………………………………………

**Other Children in household:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | DOB | Registered Here?Yes or No | Where registered if not at RGGP |
|  |  |  |  |
|  |  |  |  |

**Other adult family members in same household:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | DOB | Relationship to child | Registration here?Yes or no |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Previous or current contact with Social Services: Yes No**

**Parent/Representative to sign below to acknowledge:**

* **Novum Health Partnership Patient Agreement.**
* **We require all patients to choose a pharmacy of choice for Electric Prescription Service**
* **By signing this application you are giving consent for the practice to use your data as set out in out in General Data Protection Regulations – Practice and Patient Privacy Information sheets. They can both be found at** [**www.novumhealth.co.uk**](http://www.novumhealth.co.uk)

**Signed……………………………………….**

**Date…………………………………………..**

**For Practice Use only**

|  |  |
| --- | --- |
| **Date Accepted:** |  |
| **Name of Receptionist who checked form:**  |  |
| **Missing/Vulnerable Families Register checked (admin)** |  |
| **Child’s Red immunisation book and birth certificate attached to application:** |  |
| **Safeguarding Lead/Social Services Involvement?** |  |
| **Named Accountable GP, patient informed:** |  Dr Chen / Dr Febles / Dr Ho |
| **Details entered on EMIS:**  |  |
| **Photocopy of GMS1 if under 5 years for Health Visitors:** |  Yes or No |

**Novum Health Partnership Patient Agreement**

**Please understand that by completing and signing this form you agree to the following:**

1. That you have completed the registration questionnaire to the best of your knowledge.
2. To keep your appointments and if you are unable to do so you will inform the practice as soon as possible. (We will remind you of your appointments by text if you give us a mobile number).
3. To keep us updated of any change of address or telephone number
4. To behave towards the Practice staff as you would expect us to behave towards you, not using threatening, aggressive or bullying behaviour towards our staff / other patients.
5. To not deface or cause damage to any part of the building or its grounds.

**Signature on behalf of Patient:**...................................................... **Date:** ....... / ....... / .......

**Name:…………………………………………………..Relationship:……………………**

**What Happens Next?**

* Please take these completed forms to the Practice anytime Monday – Friday between 8.30am – 6.30pm together with your child birth certificate and red childhood immunisation book, and you can expect to be registered within 7 working days.
* Please log into our practice website for information of services that we provide [www.novumhealth.co.uk](http://www.novumhealth.co.uk) .

* If we are unable to register you, we will notify you of the reasons in writing.
* Your NHS medical card will be sent to you from NHS England within 12 weeks of registration if you are new to the area.
* Your named GP will be Dr…………..………... but you are entitled to see any Doctor at the Practice.
* You are encouraged to ask to see the same Doctor whenever you book a routine appointment. For an urgent appointment you will be allocated any of the doctors available for the session.

**THANK YOU FOR COMPLETING THIS FORM.**