Form BB

Saltscar Surgery

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NEW BABIES New Registration Questionnaire

Failure to complete all details may result in non-registration

Today's Date: ______________

Child's Name(s): ___________________________ Child's Date of Birth: ______________

Address: ____

____ Postcode: ______________

Telephone Number: (Must Complete) _________________________________

Mobile Number: _____________________

Would you like SMS text message reminders about your child's appointments **YES/NO)**

Ethnic Origin: Please Tick One:

White British	
White Irish	
Other White Background	
Black Or Black British Caribbean	
Black Or Black British African	
Other Black Background	
Asian or Asian British Indian	
Asian or Asian British Pakistani	
Asian or Asian Bangladeshi	
Asian or Asian Chinese	
Other Asian Background	
Mixed White and Black Caribbean	
Mixed White and Black African	
Mixed White and Asian	
Other Mixed Background	
Other Ethnic Background	

Mother's Full Name: _________________________ Date of Birth: ______________________

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IMPORTANT INFORMATION ABOUT YOUR HEALTH RECORDS

Please read and choose on of the three options

Ask for help from a member of staff of you are not sure

Do you give permission for the surgery to share your child's information with other Healthcare Providers when you visit them to be seen or if the child is admitted to A&E in an emergency?

For more information please read the attached leaflet *Your Electronic Health Record*

Please choose and sign just one option below:

NOTE: If you choose not to specify a preference, the records *will be* shared on the grounds of good healthcare practice.

Option 1

After reading the above leaflet I am happy for my child's full patient record to be viewed by health and care organisations involved in my child's care **without an extra verification step**.

Signature: ______________________________ Date: ________________________________

Option 2

After reading the above leaflet I DO NOT want my child's patient data to be viewed by **other** health and care organisations involved in my child's care.

Signature: ______________________________ Date: ________________________________

Option 3

I would like to provide an extra security code, or online approval to health and care organisations involved in my child's care in order to view my record.

For this option to work, you must keep your mobile number and email address up to date or have access to your GP online account.

Signature: ______________________________ Date: ________________________________

For office use only – *Admin clerk to confirm each entry is checked*

☐ SMS	☐ Record Sharing	☐ NoK
☐ M-jog	☐ Med Hist & Ethnicity	☐ Recoded
☐ SI / SMS Consent	☐ SCR	☐ Tasked

Input by: __________________________ Date: ___________________________