New Patient Child Questionnaire for Newborns

To help your doctor have full details of your medical history, we would be most grateful if you would complete this form.

Full Name	
Date of Birth	
Telephone Number	
Parents Mobile/Work Number	
Do you consent to contact via text message	Yes NO

Ethnic origin (please tick the relevant box)					
White		British	Black		Caribbean
		Irish			African
		Any other White background			Any other Black background
Mixed		White and Black Caribbean	Asian		Indian
		White and Black African			Pakistani
		Any other mixed background			Bangladesh
					Any other Asian background
Other		Chinese			
		Any other ethnic group	Not stated		Not stated/unknown

1st Spoken Language	
Summary Care Record – Your summary Care Record contains basic information including your contact details , NHS Number , Medications & allergies. This can be viewed by GP practices , hospitals and the Emergency services. If you do not want a Summary Care Record , please ask your GP practice for the appropriate opt out form. With your consent , additional information can be added to create an Enhanced Summary Care Record. This could include your care plans which will help ensure that you receive the appropriate care in the future.	**YES** (Recommended Option) **NO**

Do you consent for us to share your child's medical records with other medical service you may be using? Next Of Kin Details	Yes No Name Relationship Contact Method Registered With Us **YES** **NO**
Would you like to sign up for York Medical Group On-line system to book/cancel appointments, order repeat prescriptions and view your child's medical records?	To sign up for the On-line system, please ask at reception or for more information go to the York Medical Group website – Appointments – Help with online services