STRAND MEDICAL GROUP

NEW PATIENT QUESTIONNAIRE AGE UNDER 16

Please fill in the details requested in this questionnaire as fully as possible and return to the Practice with your registration documents.

If required, an initial appointment with a clinician can be arranged on joining the Practice.

PERSONAL DETAILS

SURNAME: ..... FIRST NAME: .....

DATE OF BIRTH: ..... FEMALE: ☐ MALE: ☐

ETHNICITY: ..... MAIN LANGUAGE: .....

NAME OF PARENT/GUARDIAN: .....

PARENT HOME TELEPHONE: .....

PARENT/GUARDIAN MOBILE .....

By providing a mobile number you consent to receiving SMS text messages from Strand Medical Group

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Are you allergic to any medicines? YES: ☐ NO: ☐

If yes, please specify: .....

Are you allergic to anything else? YES: ☐ NO: ☐

If yes, please specify: .....

Nominated Pharmacy for electronic prescribing: .....

I **do** / **do not** (*delete as applicable*) consent to having a Summary Care Record. If no option is chosen, the default option will be that we will not create a record for you.

For further details on the Summary Care Record, please see NHS Choices website at: http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Pages/overview.aspx

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Name: ..... Signature: ..... Date: .....

Thank you for taking the time to complete this questionnaire.