

## CHILD NEW PATIENT REGISTRATION (under 16)

<b>Child's Name</b>	
<b>All previous names</b>	
<b>Child's current home address</b>	
<b>Child's previous home address details</b>	
<b>Present School</b>	
<b>All previous schools</b>	
<b>Previous GP</b>	
<b>Previous Health Visitor and / or School Nurse</b>	
<b>Mother</b>	Name: Date of Birth: Address:  Home Tel: Mobile: Emergency contact number:
<b>Father</b>	Name: Date of Birth: Address:  Home Tel: Mobile: Next of Kin? YES / NO Can the child's records be discussed with the father? YES / NO Can the father be contacted in an emergency? YES / NO If so, what is the emergency contact number?

<b>Name of person(s) with legal parental responsibility</b>							
<b>Name and contact details of primary carer if different from above</b>		Name: Address:  Home Tel: Mobile:					
<b>Name and contact details of any significant other persons</b>		Name: Address: Home Tel: Mobile: Next of Kin? YES / NO Can the child's records be discussed with them? YES / NO Can they be contacted in an emergency? YES / NO					
<b>Ethnic Origin (select one)</b>		White British 9i0		White Irish 9i1		White Other 9i2	
Mixed White & Black Caribbean 9i3		Mixed White and Black African 9i4		White & Asian 9i5		Other Mixed Background 9i6	
Indian / British Indian 9i7		Pakistani / British Pakistani 9i8		Bangladeshi / British Bangladeshi 9i9		Other Asian Background 9iA	
Caribbean 9iB		African 9iC		Other Black Background 9iD		Chinese 9iE	
Other 9iF		Ethnic Category declined / not stated 9iG					
<b>Main or 1<sup>st</sup> Language Spoken / Understood (select one)</b>		English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi
Polish	Ukrainian	French	German	Spanish	Other: (Please Specify)		
<b>Specific Needs:</b> Please detail below any specific needs the child has so the practice can ensure they are identified and accommodated by taking the appropriate action							
Does the child require the help of a Translator / Interpreter?							
Please state any Sensory Impairment the child has (i.e. Speech, Hearing, Sight):							
Please state any Physical disabilities the child has							
Does the child have any communication / information needs relating to a disability, impairment or sensory loss, and if so, what are they?							

<b>HEALTH STATUS QUESTIONNAIRE</b>		
<b>Child's Medical Background</b>		
What illnesses have they had and when?		
What operations have they had and when?		
Do they have any medical problems at present?		
Allergies: Please list any drug and food allergies they have		
<b>Current Medications</b>		
Please list the name, dose and how often you are taking the medication. If possible please provide us with a repeat prescription slip from the previous GP surgery.		
Name	Dose	How many times during the day do you take it?
<b>Family Medical History</b>		

Have you or any of the child's immediate relatives (brothers/sisters/parents) had any of the following. Tick box if applicable and give details if you can.				
	TICK	Details	Relationship	Date (if known)
Heart attack or angina before age 60				
Heart attack or angina over age 60				
Asthma				
Diabetes				
Stroke				
Cancer				
Any inherited diseases				

Signed \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

**Thank you for completing this form**

***For more information about the services we offer, please refer to the new patient pack or see our website:  
[www.newbridgesurgerywolverhampton.nhs.uk](http://www.newbridgesurgerywolverhampton.nhs.uk)***