CHILD NEW PATIENT REGISTRATION (under 16)

Child's Name	
All previous names	
Child's current home address	
Child's previous home address details	
Present School	
All previous schools	
Previous GP	
Previous Health Visitor and / or School Nurse	
Mother	Name: Date of Birth: Address: Home Tel: Mobile: Emergency contact number:
Father	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?

Name of person(s) with legal parental responsibility	
Name and contact details of primary carer if different from above	Name: Address: Home Tel: Mobile:
Name and contact details of any significant other persons	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

Ethnic Origin (select one)	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		

Main or 1st Language Spoken / Understood (select one)		English	Hindi	Gujurati	Urdu	Bengali /Sytheti	Punjabi
Polish	Ukrainian	French	German	Spanish	Other: (Please Specify)		

Specific Needs: 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?	

HEALTH STATUS QUESTIONNAIRE

Child's Medical Background

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	

Current Medications

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?

Family Medical History

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