hurley group

FAMILY DOCTOR REGISTRATION SERVICES
UNDER 16 YEARS OLD

For Official Use Only:

Form Accepted by:	
New patient health check appointment	

Dear Parent/Guardian

By answering the questions on this form you will be helping us to deliver better services to your child. It is hoped that this will give us a better picture of the local population, which will help in planning new services and changing existing ones.

We encourage all patients to complete this form on behalf of your child. The information you provide will be treated in the strictest confidence. Information you give will be treated in the same way as other information we hold within the health service and will not breech the Data Protection Act 2003. As has always been the case, no names or other identifying details are released from the practice when information is used for health service planning.

If you need any help to fill in this form, any **communication support** *needs (i.e. large print, easy read format, hearing aid, British Sign Language, language interpreter)* or have any queries regarding this form, please feel free to ask the reception team.

Thank you for your help.

Master □ **Miss** □ **Other** □

Surname ______________________________ **DOB**_____/____/______

First Name(s) ______________________________

Previous Surname______________________________ **NHS Number** ____________________

Male □ **Female** □

Home Address

____

Telephone Number: 020 ____________________ **Mobile Number** ____________________

E-mail Address *(this will only be used for surgery correspondence)*

____

Please help us to trace your previous medical records by providing the following information;

Previous Address in the UK

____

____

Name and Address of your previous doctor

____

____

If you are from abroad

Your first UK address where registered with a GP

____

____

Date you entered the UK ______________________________
Country of Birth:
Place of Birth:

Are you a carer?

i.e. Do you look after a friend or a relative who is sick, disabled, elderly has a mental heath problem or for any other reason?
Yes ◻ No ◻

Are you cared for?
i.e. Do you have a friend or relative who helps you live your day to day life?
Yes ◻ No ◻

If yes please give details of your carer's contact information:

Name ____

Contact Number: ____

Family Details * (COMPULSORY TO FILL IN) *****

Mother's Name		**Contact no:**	**Registered at Allerton Road Medical Centre?** Yes ◻ No ◻
Father's Name		**Contact no:**	**Registered at Allerton Road Medical Centre?** Yes ◻ No ◻

Brothers, Sisters or other children's details living in your home * (COMPULSORY TO FILL IN) *****

Surname	First Name	Date Of Birth

Name, Address & Telephone Numbers

Child Minder * (COMPULSORY TO FILL IN) *****

Name: **Address:**	**Contact no:**

Nursery * (COMPULSORY TO FILL IN) *****

Name: **Address:**	**Contact no:**

School * (COMPULSORY TO FILL IN) *****

Name: **Address:**	**Contact no:**

Child Examinations

6 Week Examination	**Date:**
7-9 Month Examination	**Date:**
2 Year Examination	**Date:**
3 ½ Year Examination	**Date:**

Immunisations

BCG (Usually given before child's 1st birthday)	**Date:**
Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type b, Pneumococcal, Rotavirus (2 months old)	**Date:**
Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type b, Meningococcal C Rotavirus (3 months old)	**Date:**
Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type b, Pneumococcal (4 months old)	**Date:**
Hib/Men C Pneumococcal Measles, Mumps, Rubella (12 months old)	**Date:**
Measles, Mumps, Rubella (15 months old)	**Date:**
Diphtheria, Tetanus, Pertussis, Polio, (3years 4 months or soon after)	**Date:**
Human Papillomavirus (girls only aged 12 – 13yrs)	**1st Jab Date:** **2nd Jab Date:** **3rd Jab Date:**
Diphtheria, Tetanus, Polio, Meningococcal C (13-18 years old)	**Date:**

If there are any other vaccines your child has had that are not listed above please use the space below to provide the details of the jab, name and date they were given.

Has your child had any serious illnesses or operations in the past, if so please give details in this space.

Does your child have any current medical conditions?

Name of condition	**Current treatment / Medication?**

Does your child have any allergies?

Medication	Food	Anything Else

***** EPS (Electronic Prescription Service) ******

EPS makes it easy for your prescriptions to be sent electronically to the pharmacy or dispenser of your choice.

***** Nominated pharmacy :** ______________________ **Postcode:** ______________________

Smoking

If your child is over the age of 15 please can you tell us if they smoke?

Smoker: Yes □ No □

If yes how many?

Ethnic Status & Nationality

What is your child's country of birth? ________________________ What is your child's main spoken language? ________

What language does your child prefer to read? _________________________

Please tell us your child's ethnic group by ticking the box

White British □
White Irish □
White Scottish □
White Welsh □

Asian or Asian British □
Bangladeshi □
Indian □
Pakistani □

Mixed Background □
White & Asian □
White & Black African □
White & Black Caribbean □

Black or Black British □
African □
Caribbean □

Chinese □
Vietnamese □
Jewish □

Any other ethnic background please write. ____

SIGNATURE ON BEHALF OF CHILD: ____DATE___________

Are you, please circle one of the following: Child's parent Foster Parent Guardian

Thank you for taking time to complete this.
Please ask at reception for a practice leaflet to explain the services we offer