NEW PATIENT REGISTRATION FORM – CHILD

Please complete the sections below in addition to the family doctor services registration form and return to us with a copy of your medication. This must be a repeat slip or printout from your previous practice.

|  |  |
| --- | --- |
| Title: | Mr Miss  |
| Surname: |  |
| First name(s): |  |
| Date of birth: |  |
| Parent/Guardian details: | Name:Date of birth:Relationship to child: |
| Address & Post code: |  |
| Contact details:  | Home phone number:  Mobile:Please tick to receive text updates and reminders: |
| Have you previously been registered at Estuary Group Practice? | YES NO  |
| Ethnicity: |  |
| Main language:  |  |

Health history

|  |  |
| --- | --- |
| Does your child have any significant medical issues? | YES NO If YES please give details: |
| Does your child have a disability or any sensory/communication difficulties? | YES NO If YES please give details: |

Medication & Allergies

|  |  |
| --- | --- |
| Is your child taking any regular medication?**Please attach your child’s reorder form if you have this available – this will ensure there are no delays in processing your initial prescription request** | YES NO If YES please give details including medication name, dose and frequency: |
| Does your child have any known drug allergies? | YES NO If YES please give details: |

CHILDREN UNDER 5 – NEW REGISTRATION

FAO: HEALTH VISITORS

|  |  |
| --- | --- |
| Date of registration with Estuary Group Practice: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Child’s full name: |  |
| Date of birth: |  |
| Address & post code: |  |
| Telephone number: |  |
| Is your child up-to-date with immunisations?  | Yes No If you have recently moved to the UK and this is your first registration with a GP Practice, please enclose a copy of your child’s immunisation history. |
| Does your child have any outstanding health appointments?   | Yes No If yes, please provide details: |
| Previous details:Address & post code: |  |
| Previous Health Visitor & GP Practice: |  |