NEW PATIENT APPLICATION FORM FOR PATIENTS

AGED 16 AND UNDER

PLEASE COMPLETE THIS APPLICATION FORM IN FULL AND RETURN IT **PHOTO ID** or **CHILD’S BIRTH CERTIFICATE**

**PERSONAL DETAILS**

Child’s full name ……………………………………………. DOB: ……………………………

Parent/Guardian Name: ………………………….…………………………………………………

**(If you are the child’s guardian please provide proof of guardianship)**

Have you provided proof of guardianship?

Home tel. no.……………………………….. Mobile tel. no.………………………………...

 **(If patient is 16-18 please state if this is own mobile or parents)**

Email address………………………………………………………………………………….

**(All patients aged 16 and over MUST have their own e-mail address for online booking purposes)**

Opt in for onlineservices Opt out for onlineservices

School/Nursery attended (under 18’s)…………………………………………………………….

**What is your main language**? (If not English)……………………………………………

Do you need an interpreter? *YES/NO*

REPEAT MEDICATION

Please list all the medication you currently take including dose & strength or provide a copy of your current repeat medication sheet

…………………………………………… ……………………………………………

…………………………………………… ……………………………………………

…………………………………………… ……………………………………………

…………………………………………… ……………………………………………

FAMILY HISTORY

Has any close family had any of the following (please specify family member):

Diabetes………………………………… Asthma………………………………………..

Heart Disease………………………….. High Blood Pressure……………………….

Stroke…………………………………… Tuberculosis…………………………………

Eczema…………………………………. Migraine……………………………………….

Cancer (please specify type)………………………………………………………………………

LIFESTYLE

Diet - What type of diet do you have? (E.g. vegetarian, mixed, low fat, gluten free)

………………………………………………………………………………………………..

What is your child’s approximate Height? ……………………. Weight? ………………….

MEDICAL HISTORY

Do you have any of the following? (Please tick and include details)

ALLERGIES ………………………………………………………………..

MEDICATION ALLERGIES …………………………………………………………………

ASHTMA …………………………………………………………………

DIABETES …………………………………………………………………

SERIOUS ILLNESS …………………………………………………………………

Are you receiving any ongoing medical treatment? YES/NO

If yes, give details of condition treated ………………….........................................................

Are you currently under the care of a Hospital? YES/NO

If yes, please indicate which Hospital and Department/Consultant

……………………………………………………………………………………………………………………………………………………………………………………………………………………

IMMUNISATIONS (please give the date of last vaccinations)

Tetanus…………………… Polio…………………… BCG……………………..

Any other (including travel vaccinations) ……………………………………………………...

………………………………………………………………………………………………..

………………………………………………………………………………………………..

………………………………………………………………………………………………..

FOR CHILDREN AGED 5 AND UNDER - YOU WILL NEED TO PROVIDE DETAILS OF ALL CHILDHOOD IMMUNISATIONS

Have you handed in the Red book/Documentation of immunisations? 

HOW WOULD YOU DESCRIBE YOUR CHILD’S ETHNIC GROUP?

***Please tick the box appropriate to your child***

|  |  |  |
| --- | --- | --- |
| **WHITE** | British (9i0) |  |
|  | Irish (9i1) |  |
|  | Any other White background (9i2) |  |
| **MIXED** | White & Black Caribbean (9i3) |  |
|  | White & Black African (9i4) |  |
|  | White & Asian (9i5) |  |
|  | Any other mixed background (9i6) |  |
| **ASIAN OR ASIAN BRITISH** | Indian (9i7) |  |
|  | Pakistani (9i8) |  |
|  | Bangladeshi (9i9) |  |
|  | Any other Asian background (9iA) |  |
| **BLACK & BLACK BRITISH** | Caribbean (9iB) |  |
|  | African (9iC) |  |
|  | Any other Black background (9iD) |  |
| **OTHER ETHNIC CATEGORIES** | Chinese (9iE) |  |
|  | Any other ethnic category (9iF) |  |
| **NOT STATED** | Not Stated (9iG) |  |

**Parent/Guardian Signature………………………………. Date……………………..**

**FOR SURGERY STAFF USE ONLY**

Proof of address:

**(Please put type of POA seen - must be dated within last 1 month - DO NOT photocopy)**

………………………………………………………………………………………………

Type of Photo ID taken (please photocopy)…………………………………………….

Application form checked by……………………………………………………………..

Surgery Registering at……………………………………………………………………..

Completed Registration forms checked by………………………………………………

New Patient Medical date…………………………………………………………………

**Updated 08.02.2022**