New Patient Registration Form (Child: under 18 years)

Whilst we are waiting for your child's full medical records from their last doctor, it would help us if you could take the time to complete this questionnaire so that your child's care is transferred as seamlessly as possible.

- **Please complete in BLOCK CAPITALS and tick relevant boxes**
- **Please complete a separate form for each patient to be registered**
- **Please bring in your child's red book so we can take a copy of their immunisation record**

1 Your Child's Personal Details.

Title:			
Full name:		**Date of Birth:**	
		NHS No (if known):	
Gender:	□ Female	□ Male	□ Unspecified
Current Address:		**Home tel. number:**	
		Mobile tel. number:	
		E-mail address:	

- **When handing in please remember to bring photo ID & proof of address of registering adult**

2 Required Information.

Name of parent(s) / Carer(s)	Has legal responsibility?	Next of kin?
1.	Yes/No	Yes/No
2.	Yes/No	Yes/No

Name of person(s) with legal responsibility if not above:

Name of school/nursery attended:

Is child home educated? Yes/No

Please list other family members at your address . Are they registered with us?:

Name:	Relationship to child:	Registered with us Y/N

3	**Your Child's Background Information.** Due to government policy, we are obliged to ask you the following:			
	Your Child's Religion: *(please state)* Please let us know if you feel your religion will affect any treatment you receive			
	Your Child's Ethnic Origin: *(please tick one)*			
	□ Black Caribbean/British	□ White (UK)	□ Indian/British Indian	□ Arabic
	□ Black African/British	□ White (Irish)	□ Pakistani/British Pakistani	□ Chinese
	□ Other Black Background	□ White (Other)	□ Bangladeshi/British Bangladeshi	□ Other: *(please state)*
	□ Other Mixed Background: *(please state)*		□ Other Asian Background	□ I do not wish to state my child's ethnic group
	What is your child's main spoken language?			
	Does your child need an interpreter?		□ Yes	□ No
	Does your child need help with mobility/communication? (please tick all that apply)			
	□ Wheelchair	□ Walking aid Please specify:	□ Hearing aid	□ British sign Language (BSL)	□ Makaton sign language
	□ Lip reading	□ Large print	□ Braille	□ Other:	
	Is your child currently:	□ Homeless	□ A refugee	□ An asylum seeker	
	Is your child currently housebound? If so, please provide details:		□ Yes	□ No
	Is your child a looked after child under the care of the local authority?		□ Yes **If yes, in what capacity?** □ Temporary □ Permanent **Which local authority?** **Name of social worker**.	□ No
	Is your child or family currently involved with Childrens services or have they ever been known to Childrens services or the safeguarding team?		□ Yes **If yes, please give further details** **Name of social worker**	□ No

4	**Looking after a family member/carer.**	
	Is your child looking after someone at home? **If so, who:** Please let us know if your child is looking after someone who is ill, frail, disabled, has mental health/emotional support needs, or substance misuse problems.	□ Yes □ No
	If so, do you think they would like additional support as a young carer?	□ Yes □ No
	Is your child known to services such as young carers?	□ Yes □ No
	Is your child being looked after by a friend, neighbour in their home? **Private Fostering** **If yes how long have they been living there?**	□ Yes □ No
	Is someone looking after your child at home? Please let us know if a family member, friend or neighbour helps to look after your child.	□ Yes □ No
	Carer's name and address:	**Relationship to you:** **Carer's Tel. number:**

5	**Your Child's Medical Background.**		
	Please give information about any serious illnesses, operations, or injuries your child has had in the past?		
	Condition	**Year Diagnosed**	**Ongoing Yes / No**
	Is your child registered with a dentist? To find a dentist visit NHS Choices **www.nhs.uk**		□ Yes □ No
	Please provide details of any medication your child takes (including the contraceptive pill):		
	Name:	**Dosage:**	**Frequency:**

Please give details of any allergies or sensitivities your child may have to medication/food:

Family History

Please let us know if any of the following have affected your child's parents/brothers/sisters:

Please list and specify which family member:

□ Heart disease UNDER the age of 60 Who:	□ Thyroid disorder Who:	□ High blood pressure (Hypertension) Who:	□ Learning difficulties Who:	□ Mental Health problems (e.g. Depression) Who:
□ Heart disease OVER the age of 60 Who:	□ Asthma Who:	□ Stroke (CVA) Who:	□ Epilepsy Who:	□ COPD Who:
□ Cancer Who:	□ Diabetes Who:	□ Renal/Kidney Who:	□ Other:	

7 Your Child's Online Access.

You are now able to book appointments and order repeat prescriptions for your child online.

Would you like to register your child for online services?	□ Yes □ No

If yes, please complete and hand in the online registration form in this pack.

8 Parent/Guardian permission given.

Permission given for someone other than a Parent/Guardian to accompany your child to an appointment? E.g. Grandparent, Nanny, childminder

Name of person(s):	**Parent/Guardian Signature:**

9 Your signature.

Parent/Guardian Signature:	**Date:**

Thank you for completing this form
Please see our practice leaflet/website for further information about our team/services.
www.farnhamgps.com/