New Patient Health Questionaire for Under 16 years of age

Skegby Family Medical Centre
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Patient Details

First Names: Surname: Previous Surname(s):	Date of Birth: Sex:
Home Address: Postcode:	Home Tel: Mobile: Email:
Consent for Text messaging service: Please tick ☐ Yes ☐ No	
Preferred form of contact: Please circle Letter Text Email	
Name & Address of Previous GP:	
Name & Address of Current School:	
We operate using EPS (Electronic Prescription Service). All prescriptions will be sent electronically from the practice to your nominated Pharmacy. **Please nominate a pharmacy to receive your prescriptions:**	

Ethnic Group

Ethnic origin

White	Black	Asian	Chinese	Mixed	Other	Decline
☐	☐	☐	☐	☐	☐	☐

Proof of Identify

☐ **Birth Certificate**	☐ **Passport**	☐ **Hospital Letter/GP Letter**
☐ **Child Tax Credit Letter**	☐ **Child's Red Book**	☐ **Other (Please state)**

Medical Information

Please list any serious illnesses/operations/accidents/disabilities and the year they took place

Relationship to Child

- ☐ Parent/ Parents (Please state parent/parents full names)

  _____

- ☐ Guardian
- ☐ Carer/ Foster Parent, please provide proof of responsibility
- ☐ Other

Are there any residency orders in place for the child you are registering?

- ☐ Yes
- ☐ No

If yes please give details :

Immunisations

Are your child's vaccinations up to date ?

- ☐ **Yes**
- ☐ **No**

I believe all the information in this new patient health questionnaire to be accurate and correct to the best of my knowledge. Please sign and date below.

Signature: _____

Date: _____