TRINITY MEDICAL CENTRE – New patient **child** registration form (0-16)

Please complete this questionnaire and return it to the surgery with your GMS1 registration document, photo ID and a recent proof of address.

Surname: ……………………………………………………………………………………..

First Names: ……………………………………………………………………………………….

Date of Birth: ……………………………..

Sex: *Please tick*: [ ] Male [ ] Female [ ] Transgender [ ] Other [ ] Prefer not to say

Contact Details:

Home: …………………………………………………………..

Mobile: …………………………………………………………

School:…………………………………………………………..

Nominated Pharmacy (prescriptions to be sent to): ……………………………………….

Ethnic Origin: *Please tick*

( ) African
( ) Bangladesh/British Bangladesh
( ) British/Mixed British
( ) Caribbean
( ) Chinese
( ) Ethnic Category not stated
( ) Indian/British Indian
( ) Irish
( ) Other Asian Background
( ) Other Black Background
( ) Other Mixed Background
( ) Other White Background
( ) Pakistani/British Pakistani
( ) White and Asian
( ) White and Black African
( ) White and Black Caribbean

Do you need an interpreter? *Please tick*: [ ] Yes ……………………………………..[ ] No
(if yes, please note language here)

Do you have any communication/information needs relating to a disability, impairment or sensory loss? *Please tick:* [ ] Yes [ ] No
If "Yes", what are those needs? ……………………………………………………………………………

Who is your main carer? : (Please provide name(s) and specify nature of relationship e.g. parent, guardian etc.)
………..

Are you the main carer for a vulnerable person?
Please tick. [ ] Yes [ ] No

If yes please provide detail: ………………………………………………………………………………

Have you been subject to a Child Protection Order (in the last 3 years)?

[ ] Yes [ ] No

Do you have a current Social Worker? [ ] Yes [ ] No

If 'yes', what is their name /contact number? …………………………………………………………………….

Do you suffer from any drug or other allergies? *Please tick*: [ ] Yes [ ] No

If 'yes' please give details:

……

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ABOUT YOUR FAMILY- Has any member of your family had any of the following?

Condition	**Relationship**
Heart Problems	
Stroke / CVA	
Asthma	
Diabetes	

Please record your current **Height**: …………………….**cm** **Weight**: ……………………. **Kg**

You are welcome to use the scales available at the surgery if no other scales are available to you.

Are you up to date on your childhood immunisations? *Please tick*: [ ] Yes [ ] No

Please list all household members and each person's relationship to the child:

Name	**Relationship to Patient**	**Registered with this practice (Yes/No)**

Occasionally it may be necessary for the surgery to contact you, *please tick* whether you're happy for us to contact you via:

Home Phone [ ] Mobile [ ] Text [ ] Email [ ]

Do we have consent to leave voicemails on your mobile [ ] / home phone [ ]?

(This arrangement will remain in force until you advise us that you wish to change it.)

Thank you for taking the time to complete this form

For office use only:

ID/Proof of address seen: …………………………………...........

Date form handed in: …………………………..

Member of staff to check form: ………………………………….