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.

'Please write in BLOCK CAPITALS'

Title: Please tick: [ ] Master [ ] Miss [ ] Mx

Surname:……..

Middle Name(s):…….

First Name(s):……

Preferred Name(s):…….

Date of Birth: ……

Which gender were you assigned at birth? *Please tick:*
[ ] Male [ ] Female [ ] Intersex/Undefined

How do you identify yourself now? *Please tick*:
[ ] Male [ ] Female [ ] Transgender [ ] Non-Binary [ ] Other
[ ] Prefer not to say

Contact Details:

Home number: ……..

Mobile number:-

Guardians number:……
Childs number/email:……

School number:……

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
( ) Other: Please state:……..

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:
……
……

ABOUT YOUR FAMILY- Has any blood relative had any of the following?

Condition	Relationship	Diagnosed Over 60	Diagnosed Under 60
Heart Problems			
Stroke / CVA			
Asthma		N/A	N/A
Diabetes		N/A	N/A

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:

Date form handed in: ……..

Member of staff to check form: …….