New Patient Registration Form– Children (0 -15)

Thank you for choosing to join Hampstead Group Practice.
Please complete this form as accurately as possible using BLOCK CAPITALS.
If you have problems completing any section please ask at Reception for assistance.
The information you provide is confidential and will be kept confidential.

Personal Details

Surname: ……..First name(s)…….

Previous surname (if any): …… Male: € Female: €

Title (Mr/Ms): …… Date of Birth: (dd/mm/yy)……

Place of birth (including London Borough): ……

NHS Number (if known): …… Religion: ……

Address (include Flat number): ……

……

Post Code: ……Telephone Number: (Home) ……

Is the child or anyone else in the household registered disabled: Yes € No €

If yes, please give details of the disability: ……

Is the child a main Carer and if so for whom? ……

Next of Kin

Mother's Surname: ……First name: ……

Father's Surname: ……First name: ……

*Guardian's Surname: ……Forename: ……
(This may or may not be a parent and will have been awarded in Court.)*

Guardian's relationship to the child: ……

Please indicate who has parental responsibility for your child: ……

Next of Kin/Guardian's 'Phone No.: (Home): …… (Mobile): ……
(Please note, we may contact you by text message or email. Only include these details if you are happy to be contacted this way.)

(Work) …… Email: ……

Do you wish to have online access for booking appointments,

requesting medication & accessing medical records? Yes € No €

Medical Details

Allergies (to anything, including medicines)	Height: …… Weight: …… *For help using the health pod to provide this information, please ask at Reception.*
…… …… ……	

Family Medical History

Is there a family history of any of the following?	Yes/No	Immediate family members (only include parents/brothers/sisters)	Age when first diagnosed.
Heart attack, angina or bypass surgery			
High blood pressure			
CVA/Stroke			
Diabetes			
Asthma/COPD			
Cancer			

If you answered 'yes' to the cancer question, please give details of the site of the cancer.

Child's Medical History

Has your child had any medical problems in the past needing hospital, surgery attendance or repeated visits to the doctor? Yes € No €

If 'Yes', please give details: ……

……

Does your child have any current illnesses for which s/he is receiving treatment? Yes € No €

If 'Yes', please give details: ……

……

Is your child taking any prescribed medication/tablets? Yes € No €

If 'Yes', please list, give dose and frequency, or attach the repeat part of their past prescription.

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Vaccination Details

It is very important that we have an up-to-date record of your child's vaccinations. Please provide copies of your child's Health Record Book to the Practice so that we can record the details.

General Details
Which nursery/school/college does your child attend? ……..
If under 1 year of age, is your child breast or bottle fed? .....
How did you hear about our Practice e.g. web search, NHS choices, recommendation? ……

Signature: ……Date: ……

For Office Use Only		
	Yes	**No**
Form checked and fully completed?		
Opt Out form completed?		
Ethnicity form completed		
Vaccination documents provided?		
Receptionist's name and initials:		