

New Patient Questionnaire



To be completed for **ALL children** under the age of 16 years (including new babies)

Child's Full Name:	
Child's Date of Birth:	
Child's Place of Birth:	
Child's Home address:	
Child's Home telephone number:	
Child's NHS number (if known):	

Next of Kin information:

Please provide details:

Mothers Name:	
Mothers preferred contact number:	
Fathers Name:	
Fathers preferred contact number:	

Who has parental responsibility for the child?	
Is the child you are registering "looked after" by the local authority or subject to a Child Protection Plan?	YES / NO
Does the child/your family have a social worker?	YES / NO
Is your child a carer for you or someone else?	YES / NO

If yes, please provide details:

Does your child have any medical conditions?	YES / NO
Do you consider your child to have a disability?	YES / NO
Does your child take any regular medicines?	YES / NO
Does your child have any allergies?	YES / NO

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Is your child up to date with their childhood vaccinations?	YES / NO	If known, please list vaccinations received or alternatively provide a copy of the vaccination record from the Red Book :
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Ethnic Origin and Nationality:

This questionnaire follows the recommendations of the Equality and Human Rights Commission Act.

A White

- British or Mixed British
- Irish
- Other white background, please specify:
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B Mixed Background

- White and Black Caribbean
- White and Black African
- White and Asian
- Other mixed background, please specify:
.....

C Asian or Asian British

- Indian
- Pakistani
- Bangladeshi
- Chinese
- Other Asian Background, please specify:
.....

D Black or Black British

- Caribbean
- African
- Other Black Background, please specify:
.....

E Other

Please specify:
.....

Name of the person completing this form:	
Relationship to the child:	
Signature:	
Date:	