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:**
Parents Name:	
Parents preferred contact number:	
2nd Parents Name:	
2nd Parents 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:

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:	