

Dr J D Huck
 Dr Jane O'Donnell
 Dr S H Whitehead
 Dr A D W Bone



GUILDHALL SURGERY, CLARE

CHILD UNDER 16 - NEW PATIENT INFORMATION

Personal Information

Surname:	Title:
First Name (s):	Known as Name:
Date of Birth:	Age:
Full Address (Inc. Postcode):	
Home Tel:	

	PARENT/GUARDIAN (1)	PARENT GUARDIAN (2)	
Relationship to child:			
First Name (s):			
Surname:			
Full Address (Inc. Postcode):			
Home Tel:			
Mobile No:			
PLEASE TICK BELOW			
Registered at this Practice:			
Name of Person (s) with Parental Responsibility:			
Primary Contact: By completing this box you are indicating that you are the first contact that the surgery will use regarding your child's health			
I consent to receiving information from the practice or being contacted by: (Please tick)	Home No (Inc. SMS)	Mobile No (Inc. SMS)	E-Mail

By giving us consent to use your contact telephone numbers, you are agreeing to receive SMS and voice messages (this includes appointment confirmations, health related invitation, updating personal details)

Medical Information

Please list any serious illnesses / operations / accidents / disabilities (and for women any pregnancy related problems) and the year they took place **(Continue on a separate sheet if necessary)**

--

Please list any medicines being taken and the amount? **(Or attach repeat medication list)**

--

Are you allergic to any medicines or have any Allergies? **(If Yes, please state)**

--

Do you have any other medical issues? **(If Yes, please state)**

--

Family History

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes or any inherited disease. Please state their relationship to you, i.e. Mother/Father/Sibling/Grandparent, also state whether Male/Female

--

Childrens Immunisations

Are you childs vaccinations up to date – please circle	YES	NO
Are there any vaccinations that you do not require your child to have Please state:	YES	NO

Please can you bring your child's red Health Record book to their first appointment

PARENT/GUARDIAN SIGNATURE	DATE

Ethnic Group

This surgery, in line with other health care providers, collects information about the Ethnic origin of patients. This information can help us to meet the needs of the community and ensure that all our patients have equal access to the health care the practice provides.

Please note that we are not about citizenship or nationality but about the ethnic group to which you feel you belong. All the information we receive will be treated with the strictest confidence. It will not be used for any other purpose and will not be revealed to anyone outside the surgery.

Please complete the form below by ticking the box with the ethnic group you feel you belong to. If you are a descendant from more than one group, please tick the one you feel you most belong to, or chose the 'any other ethnic group' option.

A	White	British	
B	White	Irish	
C	White	Any other white background	
D	Mixed	White and Caribbean	
E	Mixed	White and Black African	
F	Mixed	White & Asian	
G	Mixed	Any other mixed background	
H	Asian or Asian British	Indian	
I	Asian or Asian British	Pakistani	
J	Asian or Asian British	Bangladeshi	
K	Asian or Asian British	Any other Asian background	
L	Black or Black British	Caribbean	
M	Black or Black British	African	
N	Black or Black British	Any other black background	
O	Other Ethnic Group	Chinese	
P	Other Ethnic Group	Any other ethnic group	