ALDERLEY EDGE MEDICAL PRACTICE

NEW PATIENT QUESTIONNAIRE (CHILD)

All information about patients is confidential: from the most sensitive diagnosis, to the fact of having visited the surgery or being registered at the practice. Confidential information may not be health-related. It can include anything that is private and not public knowledge.

PATIENT DETAILS

Title	☐ Master ☐ Miss	Surname	
Date of Birth		First names	
Previous Surnames			
Home Address: Postcode:		Home Tel	

Who has Parental Responsibility	
Name …………………….. …………………………… D.O.B …………………… Relationship to Patient: …………………………… Named on Birth Certificate: Yes / No Are you registered with the Practice: Yes / No If 'No' please provide contact number Tel: ………………………	Name ……………………….. …………………….. D.O.B ……………………….. Relationship to Patient: ……………………………. Named on Birth Certificate: Yes / No Are you registered with the Practice: Yes / No If 'No' please provide contact number Tel: ………………………….

If a Person/s with Parental responsibility are not present at the time of registering the Child they will need to present at Reception to complete a separate form and bring with them the Child's birth certificate and their own Photo I.D.

This information is required by the Practice to safeguard your Child's information and will be recorded on the Child's record.

Applications on behalf of a child who is in foster / residential / Kinship Care or who is not your child	
Who has legal responsibility for this child	**Contact Details**
1.	
2.	
Who can consent to medical treatment for this child	**Contact Details**
1.	
2.	

What is your first language? Do you need an interpreter?	

White	☐ **British** ☐ **Irish** ☐ **Other** (please specify)
Black	☐ **Caribbean** ☐ **African** ☐ **Other** (please specify)
Asian	☐ **Indian** ☐ **Pakistani** ☐ **Chinese** ☐ **Other** (please specify)
Mixed	☐ **White + Black Caribbean** ☐ **White + Black African**

PLEASE TURN OVER

MEDICAL INFORMATION

Have you had any medical problems?	
If you take any regular prescribed medication, please list it below:	
Are you registered disabled? (If yes, please give details)	☐ **Yes** ☐ **No**
Are you allergic to any medicines or have any other allergies? (If yes, please give details)	☐ **Yes** ☐ **No**

FAMILY HISTORY

Please state any serious illness, in particular heart disease, strokes, high blood pressure diabetes or any inherited disease

I confirm that I have the Child birth certificate and photo ID from the parental responsibility.

I am aware that the medical practice may take photocopies of the documentation provided to be attached to the completed registration form.

Signature:	**Date**

Signature:	**Date**

Office Use Only (tick as appropriate)			
Child Birth Certificate provided	☐	**Parental responsibility photo ID provided**	☐
Parental responsibility contact details in the Alert Box	☐	**Other (please state)**	☐ **……………….**