New Patient Registration Form – under 18 years

Please complete in **BLOCK CAPITALS** and tick the boxes as appropriate.

Patient details

Title:	Mr	Master	Miss	Date of birth		Date of Entry to the UK	
Surname:			First name(s)			Middle name	
Home Address:							
						Postcode:	
Parents Tel No:			Parents Mobile No:				
NHS number:						☐Yes ☐ No	
Parents Email Address:			Can we send you emails & text messages?			☐Yes ☐ No	
Religion:		Country of Birth		Ethnicity			
Name and address of previous GP:							
Mothers full name:							
Fathers full name:							
Who has parental responsibility?		Mother	Father	Other (*please state)*			

Next of kin

Name:		Relationship:	
Address:			
Postcode		Contact number:	

Other information

Do you have a vaccination record:			☐Yes ☐ No
If your child is under 1 year of age: were they premature?	☐Yes ☐ No	Do you have a red book?	☐Yes ☐ No
Name and address of nursery/school			
		Postcode	
Name of Health Visitor/School Nurse (if known)			
Has the child ever been the subject of a Child Protection Plan?	☐Yes ☐ No	If yes when	
Has your child ever been a "Looked After" child (i.e., in Foster Care or in a Children's Home)?			☐Yes ☐ No
Has your child ever been suspended or excluded from school?			☐Yes ☐ No
Has your child got a disability			☐Yes ☐ No
Are you a carer for any other children?	☐Yes ☐ No	Do you have parental responsibility?	☐Yes ☐ No
Any previous involvement with Children's Social Care?	☐Yes ☐ No	Any history of FGM / cutting?	☐Yes ☐ No

Housing

Please list all the people (children and adults) that share the house with the child and their relationship to the child

Name of Person	**Adult or Child** *(State age)*	**Relationship to child**			**Are they registered at this practice?**
					☐Yes ☐ No
					☐Yes ☐ No

GP Practice Only - New Patient Reg Forms Checked - Staff Initial / Date	
We would like to inform you that your named GP is _____at this practice.	

Parent/Guardian Name (Print):	**Date:**
Parent/Guardian Signature:	