QUEEN'S ROAD MEDICAL PRACTICE

NEW BIRTH REGISTRATION FORM

Evolution Number: ....

Appointment:...

BABY'S SURNAME...

BABY'S FORENAME(S)...

BABY'S DATE OF BIRTH...

ADDRESS...

....

....POST CODE ....

COPY OF BIRTH CERTIFICATE PROVIDED: □

PARENTAL RESPONSIBILITY ....

Ethnicity

White	Asian/Asian British	Black/Black British	Chinese/Other Ethnic group
British □	Indian □	African □	Chinese □
Irish □	Pakistani □	Caribbean □	Other □
Other □	Bangladeshi □	Mixed White/Black African □	
	Mixed White/Asian □	Mixed White/Caribbean □	

Eastern European Polish □ Latvian □ Other □

Portuguese/Madeiran □

Main language to be spoken: ....

Religion..

MOTHER'S SURNAME..

MOTHER'S FORENAME(S)..

CONTACT PHONE NUMBER(S)..
(INCLUDING MOBILE TEL.)

MOTHER's EMAIL ADDRESS ....

FATHER'S SURNAME..

FATHER'S FORENAME(S)..

CONTACT PHONE NUMBER(S)..
(INCLUDING MOBILE TEL.)

FATHER'S EMAIL ADDRESS ....

(If you **DO NOT** want to receive appointment text reminders by mobile telephone please sign here............)

Parent's mobile telephone numbers will only be recorded on children's records for texting purposes between the age of birth and 12 years of age as per Practice Protocol.

NAMES OF BABY'S BROTHERS/SISTERS

SURNAME.. FORENAME(S)..DOB.........................

SURNAME.. FORENAME(S)..DOB.........................

SURNAME…………………………………..…………… FORENAME(S)…………………………………………….……..DOB………………….

SURNAME………………..……..…………………… FORENAME(S)………………………………………….………….DOB………………….

P.T.O.

PRIVATE HEALTH INSURANCE? IF YES, PLEASE STATE COMPANY & POLICY NUMBER, IF KNOWN

……

FAMILY HISTORY

Do you or your child's brothers or sisters have any of the following?
(**M**-mother, **F**-father, **B**-brother, **S**-sister)

	Yes	**Who/age**		**Yes**	**Who/age**
Diabetes			Bowel cancer		
Asthma			Breast cancer		
High blood pressure			Ovarian cancer		
Heart attack			Any other condition		Please specify below
Epilepsy			Family history not known – adopted		

Declaration by Parent / Guardian:

I understand that the Practice has the right to accept or decline this application.

I agree to pay for all treatment given to my child by the Practice. *Full details of pricing available from reception or on our website www.eqrmp.com*

I agree that the Practice may disclose personal details and details of medical records regarding my child to all those involved in providing healthcare and related services both inside and outside the Practice.

PARENTAL RESPONSIBILITY HELD BY: ……………………………………………………………………………………

NAME ………………………………………………… RELATIONSHIP TO CHILD…………………….…………………………

SIGNED…………………………………………… DATE………………………………………………………………………….

COPY OF BIRTH CERTIFICATE RECEIVED : ☐

Patient documentation received by: ……………………………………………………………………..…………….(STAFF NAME)

SIGNED:
……….………………………

DATE:
………

FOR OFFICE USE ONLY:

REGISTERED DOCTOR……………………………………………………………..……………………………………………

DEALT WITH BY ……………………………………………………………………………………………………… (STAFF NAME)

SIGNED …………………………………………………………………………………… DATE ………………………………….