QUEENS ROAD MEDICAL PRACTICE

NEW PATIENT APPLICATION FORM (under 16 yrs)

PLEASE COMPLETE IN CAPITAL LETTERS

SURNAME…… Miss/Master

FORENAMES…… DATE OF BIRTH……..

USUALLY KNOWN AS…… HOME TELEPHONE ……

ADDRESS……..

……..

POSTCODE …….. MOBILE TELEPHONE ……

EMAIL ADDRESS .....

(If you **DO NOT** want to receive appointment text reminders on this 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.

MOTHER'S SURNAME……

MOTHER'S FORENAME(S)……..

FATHER'S SURNAME……..

FATHER'S FORENAME(S)……..

SCHOOL……

PRIVATE HEALTH INSURER……..POLICY NUMBER……..

SOCIAL INSURANCE NO…….. ETHNIC ORIGIN/LANGUAGE ……
(See below)

When attending the first consultation your child should please provide a urine specimen. Please ask receptionist for a specimen bottle.

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.

I give my permission to the Practice to request information from my child's previous doctor and I agree to meet reasonable charges relating thereto.

SIGNED…… DATE……..

NAME …….. RELATIONSHIP TO CHILD……..

Please supply photographic proof of identity for your child (passport/birth certificate, etc)

NEXT OF KIN DETAILS

NAME……. RELATIONSHIP……..

ADDRESS……. HOME TELEPHONE ……

……. MOBILE NUMBER…….

…….. WORK TELEPHONE ……..

PREVIOUS DOCTOR

NAME…….. TELEPHONE ……

ADDRESS……

WHICH DOCTOR WOULD YOU LIKE TO BE REGISTERED WITH ?…….

IF YOU HAVE MOVED TO GUERNSEY IN THE LAST YEAR PLEASE STATE:

DATE OF ARRIVAL…… INTENDED LENGTH OF STAY……

PREVIOUS ADDRESS……

……

HOW DID YOU HEAR ABOUT OUR PRACTICE? (*please delete as appropriate***)**

PRACTICE WEBSITE / BEST OF GUERNSEY WEBSITE / PERSONAL RECOMMENDATION / OTHER

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

Eastern European Polish □ Latvian □ Other □

Portuguese/Madeiran □

Country of Birth: _____

Main Language Spoken: _____

Religion……

Has your child ever been registered here before? Yes / No

Has your child seen a doctor or attended an A+E Dept within the last 12 months? If so, please give details.

Please list **all** previous addresses your child has lived at and give dates (continue over the page if required)

Please list **all** GP surgeries your child has been registered with and give dates (continue over the page if required)

Does your child have or ever had any of the following?

	Yes	No		Yes	No
1.Asthma			7.Bowel or stomach problems		
2.Epilepsy			8.Kidney or bladder problems		
3.Diabetes			9.Skin problems		
4.Faints or blackouts			10.Any operation/surgical procedure		
5.Ear, nose or throat problems			11. Visual or hearing impairment		
6.Eye problems			12.Allergy to medication/food/other		

If you have answered Yes to any of the above, please give details with dates (if applicable)

Please enter details of any immunisation/vaccination that your child has received:

Name of immunisation/vaccination	Date given	Where given	Any known side effects

Guidelines for Childhood Vaccination Schedule – full details of children's immunisation are available in the patient held "green book":

2 months:	Diphtheria, Tetanus, Pertussis, Polio, HIB, Pneumococcal
3 months:	Diphtheria, Tetanus, Pertussis, Polio, HIB, Meningitis C
4 months:	Diphtheria, Tetanus, Pertussis, Polio, HIB, Meningitis C, Pneumococcal
12 months:	HIB, Meningitis C,
13 months:	Measles, Mumps, Rubella (MMR), Pneumococcal
3yrs 4 months to 5 years:	Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella (MMR)
13-14 years: (females only)	HPV vaccine (3 doses)
13 to 18 years:	Diphtheria, Tetanus, Polio

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		

Is your child taking any medication prescribed by a doctor/specialist? If so, please give name and dose:

Please enter any other information concerning your child's health that you feel may be useful to your doctor.

Practice use only:

Original details taken by……. Appointment made……

Account number……..

Doctor seen…….. Checked in by……..

Paid/Bill Photographic ID checked by……

Date……..

Letter PMH/Accept Accepted by Doctor……..

Date……..