The Grove Medical Centre
New Patient Registration Form – Child (under 18)

Please complete this confidential questionnaire (one for each child member of the family to be registered with the Practice).

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

If you are newly arrived in this country, please bring your passport to confirm your date of birth and entitlement to NHS treatment.

For Office Use: If the child is aged 5 or under a copy of this form needs to be given to the Health Visitors. Is the patient a TEMPORARY RESIDENT? YES / NO

Full Name:	**Date of Birth:**
All Previous Surnames:	**Town & Country of Birth:**
Current Address & Postcode:	**Previous Address & Postcode:**
Mothers Full Name & Date of Birth:	**Fathers Full Name & Date of Birth:**
Mothers Address & Postcode if different & contact no:	**Fathers Address & Postcode if different & contact no:**
Previous GP & Address:	**Previous Health Visitor (for children 5 & under only): Name/Contact Details/Where are they based?:**
Present School:	**Previous School:**
Name of Primary Carer & any significant other persons & their relationship to you & the above named child (including name of person (s) with parental responsibility if different to above). This includes any other household members:	
Which pharmacy would you like to collect your regular medication from? If you live more than 1 mile from a chemist we can dispense for you at the surgery, otherwise we can send your prescription request to your nominated pharmacy. Rules regarding dispensing eligibility are very strict. If you are eligible to be a dispensing patient but opt to use a pharmacy instead you will NOT be able to change your mind at a later date. Please speak to a member of our dispensary team if you have any queries. Please circle your choice:	

Bute House Dispensary **(ONLY if you live more than 1 mile from a chemist)**	Abbey Pharmacy	Co-Op Pharmacy/Well	Boots Sherborne	Boots Babylon Hill	Boots Yeovil (Middle Street)	Sarah Allard

Your Ethnic Origin: (select one)	**White (UK) 9i0**	**White (Irish) 9i1%**	**White (Other) 9i2%**
Caribbean 9i3	**African 9i4**	**Asian 9i5**	**Other Mixed Background 9i6%**
Indian / Brit Indian 9i7	**Pakistani / Brit Pakistani 9i8**	**Bangladeshi / Brit Bangladeshi 9i9**	**Other Asian Background 9iA%**
Other Black Background	**Chinese 9iE**	**Other 9iF%**	**Ethnic Category not stated 9iG**

Your main or 1st language Spoken / Understood: (select one)		**English**	**Hindi**	**Gujurati**	**Urdu**	**Bengali /Sytheti**	**Punjabi**
Polish	**Ukrainian**	**French**	**German**	**Spanish**	**Other: (Please Specify)**		

Your Medical Background:	
What significant illnesses have you had & When?	
What operations have you had and When?	
Do you have any medical problems at present?	
Please list any tablets, medicines or other treatments you are currently taking:	

Vaccinations:

Please give details, dates and location of <u>any private vaccinations</u> that may not have been added to your NHS vaccination record (including batch numbers & expiry dates if you have them):

Thank you for completing this form