The St. James Practice

Waltham Forest NHS

New Patient Registration Form
(Under 16)

PLEASE COMPLETE ALL DETAILS AS FULLY AS POSSIBLE
Areas marked * are mandatory

PERSONAL INFORMATION

Gender *	**Male ***	**Female ***	
Surname *			
Forenames *			
Date Of Birth *		**Place & Country Of Birth * (Incl borough if newborn)**	
Mother's Full Name *		**Father's Full Name ***	
Mother's Maiden Name			
Your Current Home Address incl postcode *			
Home Phone Number			
Mobile Phone Number			
Email Address			

INFORMATION SO WE CAN TRACE YOUR MEDICAL RECORDS

NHS Number *	
Previous Address incl postcode *	

Previous GP* Name: Address:	
Has your child been registered here before?	**Yes** ( ) **No** ( ) if so, when?
If you have moved from abroad, date of arrival in the UK	
Next Of Kin Full Name*: Address: Phone Number: Relationship to child *:	**Mr** ( ) **Mrs** ( ) **Miss ( ) Ms** ( )
Does your child have a carer? Full Name: Address: Phone Number:	**Yes** ( ) **No** ( )
If you choose not to have a Summary Care Record please ask at reception for an opt-out form (SCR is an electronic record which gives healthcare staff faster, easier access to essential information about you, to help provide you with safe treatment in the event of an emergency or when your GP practice is closed).	

ABOUT YOUR CHILD'S PAST MEDICAL HISTORY

Does your child currently suffer from any medical problems/conditions/illnesses/diseases? *	**Date**	
Has your child had any significant medical problems/diseases/illnesses/operations in the past? *	**Date**	

Please list all current medication * (Or you can attach a copy of your child's previous surgery's repeat medicines list if you prefer).	

If your child is on repeat medicines you <u>must</u> make an appointment with their new GP. We would really like to review their medicines and make sure all the medicines you take are necessary and correctly prescribed. Please ask the receptionist to organise an appointment for you at a convenient time.

Does your child have any allergies? * Please also tell us the nature of the reaction.	

Family History Please tick any of the following that apply to first degree relatives (parents, brothers & sisters).	( ) Asthma ( ) CVA/TIA/Stroke ( ) Diabetes ( ) Hypertension ( ) Cancer (type) ( ) Any other inherited condition:	**Family Member Affected**

Childhood Immunisations/Vaccinations* **Please tick as appropriate** Please bring your child's Red Book or copies of immunisation records (if records are in a foreign language please ensure they are translated into English & certified).	( ) MMR ( ) Polio ( ) Tetanus ( ) BCG ( ) Rubella ( ) Pneumococcal ( ) Hepatitis B	( )Flu ( ) Other (specify)

ETHNICITY AND LANGUAGE

Ethnic Origin * Knowing your ethnic origin is important for some of our tests and may affect which medicines work best for you.	White: ( ) British ( ) Irish ( ) Other * Asian/Asian British: ( ) Indian ( ) Pakistani ( ) Bangladeshi ( ) Other * Black/Black British: ( ) Caribbean ( ) African ( ) Other * Other * ( ) Chinese ( ) Other * (*please state) ……..
First Language *	

Signature…….. Date…….. Initials of staff member …….