REDGATE MEDICAL CENTRE
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CONFIDENTIAL NEW PATIENT CHILD REGISTRATION FORM FOR CHILDREN UP TO 15 YEARS

Please complete all pages in FULL using BLOCK CAPITALS and TICK as appropriate
Your named GP is Dr Syed Akhter (you can however arrange an appointment to see a GP of your choice)

CURRENT DETAILS

TITLE		FIRST NAME		MIDDLE NAME	
SURNAME	CURRENT SURNAME			PREVIOUS SURNAME	
DATE OF BIRTH				GENDER	
TOWN AND COUNTRY OF BIRTH				NHS NUMBER	
CURRENT ADDRESS POST CODE					

WHO HAS PARENTAL RESPONSIBILITY FOR THIS CHILD? Please tell us their name/s, contact details and their relationship to the child	
PARENTAL RESPONSIBILITY Please indicate who you wish to be the FIRST CONTACT for your child First Contact ☐ Second Contact ☐	Name: Address: Home Telephone Number: Mobile Telephone Number: Relationship to the child:
PARENTAL RESPONSIBILITY Please indicate who you wish to be the FIRST CONTACT for your child First Contact ☐ Second Contact ☐	Name: Address: Home Telephone Number: Mobile Telephone Number: Relationship to the child:

PLEASE HELP US TRACE YOUR PREVIOUS MEIDCAL RECORDS BY PROVIDING THE FOLLOWING INFORMATION

PREVIOUS ADDRESS POSTCODE	
PREVIOUS GP's NAME AND ADDRESS	
IF NOT PREVIOUSLY REGISTERED IN THE UK, DATE YOU CAME TO LIVE IN THE UK	
IF PREVIOUSLY RESIDENT IN UK, DATE OF LEAVING	

HOUSEHOLD MEMBERS

Is anyone else from your household already registered with the practice? Please provide their names and date of birth

NAME OF OTHER PARENT/GUARDIAN OR NEXT OF KIN IF ANY

Name	
Relationship	
Contact Details	
Is anyone else likely to bring your child to the surgery? Is so, please provide name, relationship and contact details	
Is your child subject to a child protection plan? If yes, please give last review:	YES ☐ NO ☐ DATE:

ETHNICITY and LANGUAGE/S

White – British/Irish/Polish/Other (please specify)	
Black – Caribbean/African/Other (please specify)	
Asian – Indian/Pakistan/Chinese/Other (please specify)	
Mixed – or multiple ethnic groups (please specify)	
First Language	
Second Language	
Do you require an interpreter?	

FAMILY HISTORY

CONDITION	RELATIONSHIP TO CHILD

HAS YOUR CHILD EVER SUFFERED FROM ANY IMPORTANT MEDICAL ILLNESS, OPERATION OR ADMISSION TO HOSPITAL? If so, please enter the details below

CONDITION	YEAR OF DIAGNOSES, PROCEDURE	ONGOING
		Yes/No
		Yes/No
		Yes/No

LIST OF CURRENT MEDICATION

NAME OF MEDICATION	DOSAGE	DATE OF LAST ISSUE

IS YOUR CHILD ALLERGIC TO ANY MEDICATION

NAME OF MEDICATION	DOSAGE	DATE NOTICED

PREFERRED PHARMACY: We now have the facility to send prescriptions electronically to your preferred Pharmacy in place of sending a paper copy. Please indicate your preference of prescription and your Nominated Pharmacy.

I would like an ELECTRONIC PRESCRIPTION
I have ticked my Nominated Pharmacy below ☐

I WOULD NOT like an electronic prescription but would like my paper Prescription to go to my Preferred Pharmacy as ticked below ☐

SOMERSET BRIDGE (Jhoots)	☐	SAINSBURYS (Lloyds)	☐
STOCKMOOR (Stockmoor Park)	☐	VICTORIA PARK (Lloyds)	☐
SUPERDRUG (Bridgwater)	☐	ASDA (Bridgwater)	☐
BOOTS (Bridgwater)	☐	REDGATE (Lloyds)	☐
ROWLANDS (East Quay)	☐	TAUNTON ROAD (Lloyds)	☐
CRANLEIGH GARDENS (Bridgwater)	☐	NORTH PETHERTON (Lloyds)	☐

PLEASE INDICATE IF YOUR CHILD HAS ANY OF THE FOLLOWING CONDTIONS BELOW and if so, please arrange an appointment with the practice nurse for an annual review

Asthma	☐	Coronary Heart Disease	☐
Diabetes	☐	Any other long term condition (please give details)	

I confirm that the information I have provided is true to the best of my knowledge

SIGNED:	**DATE:**

For practice staff use only:

STAFF MEMBER NAME (please print name)	
DATE and TIME FORM COMPLETED	
PHOTOGRAPHIC ID CHECKED	
PROOF OF ADDRESS CHECKED	
DATE PATIENT REGISTERED	