CHILD - Patient registration and health questionnaire

Please provide ID evidence i.e. Birth Certificate

Please return this form to a member of the reception team who will make an appointment for your new patient health check.

<table>
<tr><td>Gender:</td><td></td><td>Date of birth</td><td></td></tr>
<tr><td>Forename(s)</td><td colspan="3"></td></tr>
<tr><td>Surname</td><td></td><td>Calling Name</td><td></td></tr>
<tr><td>Current address</td><td colspan="3"></td></tr>
<tr><td>Home phone number
Mobile phone number</td><td colspan="3"></td></tr>
<tr><td>School</td><td colspan="3"></td></tr>
<tr><td>NHS number</td><td colspan="3"></td></tr>
<tr><td>Previous address</td><td colspan="3"></td></tr>
<tr><td>Previous GP</td><td colspan="3"></td></tr>
<tr><td>Has your child been registered here previously? If yes, please give dates.</td><td colspan="3"></td></tr>
<tr><td>Has your child moved to the UK from abroad? If yes, give date of arrival in the UK.</td><td colspan="3"></td></tr>
<tr><td>Parent or guardian details:
Title:
Surname:
Forename:
Relationship:
Address:
Telephone numbers:</td><td colspan="3"></td></tr>
<tr><td>Consent: (Please delete as appropriate)</td><td colspan="3">I consent/do not consent to be contacted by SMS on my mobile number.

I consent/do not consent to be contacted by email at this address.

We may contact you with appointment details, results, health awareness events, etc.</td></tr>
<tr><td>Special circumstances:</td><td colspan="3">Please tick if any of the following apply to your child:
I have a carer
I am a carer
I have communication difficulties
Live in a children’s home</td></tr>
</table>

DR KK CHAN & PARTNERS

Height		**Weight**	
Allergies		**Disabilities**	
Is your child: **Registered blind or partially sighted** **Registered deaf** **Registered disabled**		Please state which of these apply:	
Please state your child's ethnicity			
Does your child have any drug allergies? ***Please include known reactions***			
Does your child have any other allergies? ***Please give as much detail as possible***			
Does your child suffer from any of the following: **Asthma** **Depression** **Diabetes** **Epilepsy**		Please state which of these apply and give date of last review:	
Does your child have any other serious or chronic illness?		Please explain:	
Does your child have a family history of: **Asthma** **Diabetes** **Heart disease** **High cholesterol** **Heart attack** **Stroke** **Cancer** **Liver disease** **Depression** **Epilepsy** **COPD**		Please give details including relationship, illness and age at diagnosis if known:	
Has your child had any significant injuries or major operations?		If yes, please give details:	
Current medication		If possible, attach a copy of your child's repeat prescription list.	
Medication		Dosage/ Repeat/Quantity remaining	

PARENT OR GUARDIAN DECLARATION	
I confirm that, to the best of my knowledge, the information I have provided is accurate and correct.	
Signature	
Print name	
Date	