New Patient Questionnaire

JUNIOR REGISTRATION (UP TO 16 YEARS OLD)

Date of Registration

SECTION RELATING TO PARENT OR GUARDIAN

Surname	
First Names	
Address	Postcode
Please supply us with this information, it is very important, even if you are ex-directory. We also need to have your phone number to enable you to use the automated booking system.	Home Tel Work Tel:
	Mobile:
Email	

Child's Surname	
Child's First Names	
Address (if different from above)	
Date of Birth	

Names and ages of brothers and sisters.

Have there been any health problems **YES NO** If yes, please give details.

Are both parents, brothers and sisters fit and well? **YES NO** If no, please give details.

Immunisation	TICK if received	Date	Place	TICK if GP
1st Dip/Tet/Pertussis/Polio/Hib				
2nd Dip/Tet/Pertussis/Polio/Hib				
3rd Dip/Tet/Pertussis/Polio/Hib				
1st Meningitis C				
2nd Meningitis C				
3rd Meningitis C				
OR single Meningitis C				
1st MMR				
Pre-school booster Dip/Tet/Polio/ & 2nd MMR				

We need to ask about your ethnicity. Please tick one of the boxes and enter first language below.

British or Mixed British	☐	Caribbean or Mixed Caribbean	☐
African or Mixed African	☐	Indian or Mixed Indian	☐
Asian or Mixed Asian	☐	Other	☐

Main language spoken

Any additional information?