Derby Road Health Centre

Grange Farm Medical Centre

New Patient Registration Questionnaire (Under 16's)

Patient Details

Title	Mr / Miss / Ms / Other (circle most appropriate)		Address		
First Name					
Middle Name					
Surname			Home Tel. No	Preferred contact?	
Date of Birth			Mobile Tel. No	Preferred contact?	
NHS Number			Email address		

Ethnic Origin – please circle most appropriate

White	British / Irish / Other .....
Mixed	White & Black Caribbean / White & Black African / White & Asian / Other .....
Asian or Asian British	Indian / Pakistani / Bangladeshi / Other .....
Black or Black British	Caribbean / African / Other .....
Chinese or other Ethnic Group	Chinese / Other .....
Prefer not to say..?	I do not wish to specify my ethnic origin

Spoken Language

Main Spoken Language	
Do you speak English?	
Do you need an interpreter?	

About You

Are you originally from Abroad?		If so, when did you arrive in the UK?	
Next of Kin		Relationship to you	
Next of Kin address		Next of kin contact Telephone number	
Who has Parental Responsibility for you?		Relationship to you	
Address of person with Parental Responsibility		Contact Telephone number	
Do you consent to receiving text messages to your mobile phone?			
Do you consent to us contacting you via e-mail?			
Would you like to register for on-line services / NHS App?			
Have you received a copy of our leaflet about Record Sharing?			
Are you a carer?	Yes / No (delete as appropriate)	Who do you care for?	
Are you a cared for person?	Yes / No (delete as appropriate)	Who is your carer?	Carers Name / Carer's contact Tel No.

336 Derby Road, Lenton
Nottingham, NG7 2DW
Tel: 0115 896 5001

17a Tremayne Road, Bilborough
Nottingham, NG8 4HQ
Tel: 0115 896 5002

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Nursery / School / College

Name of Nursery, School or College	Address of Nursery, School or College	Contact Telephone number of Nursery, School or College

Medical Questions about you

Do you have a 'red book'?	Yes / No (delete as appropriate) If yes please bring to the surgery so that we can enter your immunisations onto your medical record.			
If you do not have a red book do you know what immunisations you have had?	Yes / No (delete as appropriate)			
If yes, details	Please provide clear evidence of immunisations			
Do you have any known allergies?				
If yes, details				
Do you consider yourself to have a disability?				
If yes, details				
Are you a smoker? (Please tick appropriate box)	No Never			
	Ex-smoker		When did you quit?	
	Smoker		How many per day?	
Would you like help to stop smoking?				

Patient Declaration

To the best of my knowledge, all the preceding answers and information provided are true and correct	
Signature	
Print Name	
If completed on behalf of the patient – Patients Name	
Date	

January 2020

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