THE HALL PRACTICE

Hampden Road, Chalfont St Peter, SL9 9SX
01753 989800
www.thehallpractice.co.uk

NEW PATIENT REGISTARTION FORM (AGED 0-16 YEARS)

TODAY'S DATE:

Please complete this confidential questionnaire.

Please complete in **BLOCK CAPITALS** and **tick the boxes as appropriate**.

Please complete a separate form for each family member to be registered at The Hall Practice.

If you have been registered with NHS before, please let us know your NHS number and the name and address of the GP you were registered with.

PATIENT CONTATC DETAILS

Full Name:		**Gender:**
Title:	**NHS Number:**	**Date of Birth:**
Primary Address and Postcode:		
Town and Country of Birth:		
Current School/Nursery: *if applicable*		
Mother's Contact Details		
Mother's Name:		
Mobile:	**Home:**	
Email:	**Work:**	
Father's Contact Details		
Father's Name:		
Mobile:	**Home:**	
Email:	**Work:**	
Who has parental responsibility? *Name/Relationship/ Contact Details if none of the above apply.*		

Is the child under the care of Social Services?	**Yes / No**

Social Services Name and Contact Details: *if applicable*

Previous Address and Postcode: *If applicable*

Date child first came to live in England? *If applicable*

Previous GP Surgery Name and Address: if applicable

Your religion: (please select one)	**Buddhist**	**Catholic**	**Church of England**	**Other Christian (state)**	**Hindu**	**Jehovah's Witness**
	Jewish	**Muslim**	**Sikh**	**No religion**	**Other (state)**	

Your Ethnic Origin: (please select one)	**African**	**Asian**	**Bangladeshi/ British Bangladeshi**
Caribbean	**Chinese**	**Indian/ British Indian**	**Pakistani/ British Pakistani**
White (UK)	**White (Irish)**	**White (Other)**	**Other Asian Background**
Other Black Background	**Other Mixed Background**	**Other (please specify)**	**Ethnic Category Not Stated**

Your main or 1st language (please select one)		**English**	**Hindi**	**Gujurati**	**Urdu**	**Bengali/Sytheti**
Punjabi	**Polish**	**Ukrainian**	**French**	**German**	**Spanish**	**Portuguese**

Other language: (please specify)	Translator Required? Yes / No

Medical Background					
Child's Height:	**Feet/Inches**	**Cm**	**Child's Weight:**	**Stone/lbs**	**Kg**
Has your child ever had, or received treatment for any of the following conditions?					
Convulsion/Fits			**Yes / No**		
Asthma			**Yes / No**		
Diabetes			**Yes / No**		
Has your child ever had any other serious illness, injury, or operation?			**Yes / No**		
If yes, please give details, including approximate dates:					
Does your child take any medicines?			**Yes / No**		
If yes, please give details below:					
Medicine *(Name and Strength)*	**Dose**		**Frequency**	**For how long?**	

Prescriptions		
There is now the facility to nominate a chemist for your prescription to be generated electronically. Please nominate a pharmacy to collect your child's prescriptions from: Please note you will still have to order your prescription from the surgery on your chemist.	**Boots (Gerrards Cross)**	
	Health & Beauty	
	Richard Adams	
	Vantage	

	Other: *please specify*

Immunisations	**Date Given**		
	1st	**2nd**	**3rd**
BCG			
DTAP/IPV/HIB (Diphtheria, Tetanus, Pertussis/Polio/HIB)			
Pneumococcal PCV			
Rotavirus			
Meningitis B			
Meningitis C			
HIB/Men C 12-13 months			
MMR (Measles, Mumps, Rubella)			
DTAP/IPV/HIB (Diphtheria, Tetanus, Pertussis/Polio/HIB) 3yrs-4yrs 5mths			
TD/IPV (Tetanus, Diphtheria/Polio) 13-18 yrs			
Hepatitis B			
Any other immunisations?			

Are there any serious diseases that affect the child's parents and/or siblings? *(Please select all that apply)*			
Diabetes	**Heart Attack**	**Heart attack under age of 60**	**Bowel Cancer**
Breast Cancer	**High Blood Pressure**	**Asthma**	**Stroke**
Thyroid Disorder	**Any other Important Family Illness?**		

Specific Needs and Allergies Please detail below any specific needs you have so the practice can ensure they are identified and accommodated by taking the appropriate actions.	
Please state any sensory impairment your child has: *(i.e. speech, hearing, sight)*	
Is your child an 'assistance dog' user?	
Please state any physical disabilities your child has:	
Please state any mental disabilities your child has:	
Please state any requirements your child has, to be able to access the practice premises:	
Please state any religious/cultural needs your child has:	
Does your child require the help of a translator/interpreter?	
Please state any specific nutritional requirements your child has:	
Please state any allergies and intolerances/sensitivities your child has:	
Please state any phobias your child has:	

Online Access

If you need online access to your child's medical records, kindly fill out the proxy access form and get in touch with our administrative team. It's important to remember that proxy access is only granted until your child reaches their 16th birthday. After that point, proxy access will be revoked, and we will need written confirmation from the patient allowing us to communicate with you on their behalf.

Patient Signature:	
Signature on behalf of the patient:	

Thank you for completing this form.

We will contact you once your registration has been processed.

For more information about the services we provide, please visit our website www.thehallpractice.co.uk

You can also follow us on Facebook www.facebook.com/thehallpracticenhs/