

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	l Postcode:				
Town and Country of	Birth:				
Current School/Nurs	sery: if applicable				
Mother's Contact De	tails				
Mother's Name:					
Mobile:		Home:			
Email:	ail: 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 Services?	d under th	ie c	are of So	cial					Yes / No)
Social Ser	vices Nan	ne a	and Cont	act	Detai	ils:	f applicable			
Previous A	ddress ar	าd F	Postcode	: If a	pplic	able)			
Date child	first cam	e to	live in E	ngla	and?	lf ap	plicable			
Previous GP Surgery Name and Address: if applicable										
Your	Buddhist	t C	Catholic	Ch	urch		Other	F	lindu	Jehovah's
religion:				of			Christian			Witness
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select				LII	gland	•	(state)			
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one)	Jewish	ľ	1uslim	Sik	K n		No religion		ther (st	ate)
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Your Ethni	С	Afı	rican			As	ian		_	deshi/ British
Origin:									Bangla	deshi
(please se	lect									
one)										
Caribbean		Chinese			Indian/ British Indian			Pakistani/ British Pakistani		
White (UK))	White (Irish)			White (Other)			Other A Backgi		
Other Blac	ther Black Other Mixed O			Ot	her (please		_	Category Not		
Backgrour		Background		specify)			Stated			
Your main			English		Hind		Gujurati	U	rdu	Bengali/Sytheti
language	0 1 1					a I	Jajaiati			2011gati/Oytiloti
(please se	lect one)									
Punjabi	Polish		Ukrainia	an.	Fren	nch	German	C	panish	Portuguese
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			1							







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

Medical Background						
Child's Height:	Feet/Inches	Cm	Child's Weight:	Stone/lbs Kg		
	r had, or recei	ved treatr	nent for any of the f	ollowing		
conditions?						
Convulsion/Fits			Yes	Yes / No		
Asthma			Yes	s / No		
Diabetes			Yes	s / No		
Has your child eve	r had any othe	er serious	Yes	s / No		
illness, injury, or operation?						
If yes, please give details, including approximate dates:						
Does your child take any medicines?			Yes / No			
If yes, please give details below:						
Medicine (Name	Dose		Frequency	For how long?		
and Strength)						

Prescriptions	
	Boots (Gerrards Cross)
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:	Health & Beauty
Please note you will still have to order your prescription from the surgery on your chemist.	Richard Adams
	Vantage









Other: please specify

Immunisations	Date Given		
	1 st	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 tha	(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?				



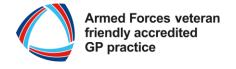




Specific Needs and Allergies

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/

