

Type your text

EDRIDGE ROAD COMMUNITY HEALTH CENTRE

PATIENT REGISTRATION FOR CHILD UNDER 18 YEARS

PLEASE WRITE IN BLOCK CAPITALS

Surname:

D.O.B.:

First Names:

NHS No:

Address:

Post Code:

Place and Country of Birth:

Home telephone No:

Name of Primary Carer:

Other Household Members:

Surname

First Name

Relationship

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1st Language:

Interpreter Needed:

YES / NO

School:

Religion:

Immunisation History:

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.....

Copy of Immunisations Record Provided:

YES / NO

MEDICAL HISTORY
Has your child ever had the following

Diabetes	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Asthma	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Learning Difficulties	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Speech Problems	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Bedwetting/soiling	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Disability	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Emotional/Behavioural Problems	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

If YES, please give details below:

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Please list below, with approximate dates, any other illness including operations and hospital admissions:

.....

Please list any medications your child is currently taking:

Please list any allergies:

Is there any family history of:

Heart problems	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Asthma	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Stroke	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Diabetes	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Depression	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Mental Health problems	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Disability	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Drug/Alcohol abuse	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

If YES to any of the above, please give details and relationship:

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Has your child ever been referred to any of the following:

Social Services	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Psychologist/psychiatrist	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
Speech therapist	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

If YES to any of the above, please give details, including dates:

.....
 ...

CODE NO		
9S10.	White British	
9S11.	White Irish	
9S12.	Other white ethnic group	
BLACK OR BLACK BRITISH		
9S2..	Black Caribbean	
9S3..	Black African	
9SG..	Other black ethnic group	
ASIAN OR ASIAN BRITISH		
9S6..	Indian	
9S7..	Pakistani	
9S8..	Bangladeshi	
9SH..	Other Asian ethnic group	

CODE NO	OTHER ETHNIC GROUPS	
9S9..	Chinese	
9SJ..	Other ethnic group	
MIXED		
9SB5.	White and Black Caribbean	
9SB6.	White and Black African	
9SB2.	Other ethnic, Asian/White origin	
9SB4.	Other ethnic, other mixed origin	
9SD..	ETHNIC GROUP NOT GIVEN	

OFFICE USE ONLY

Date of application: Registering with Dr.....
 Doctor Appointment: Dr/Date: Nurse Appointment: Nurse/Date:
 Receptionist: New Patient Admin: Clinical Review:
 Summarising: