Drs Miller, Anderson and Fleming

New patient registration form for under 16 year olds

Please complete all the following details and tick/circle the shaded boxes. This information will be treated in strictest confidence.

|  |  |
| --- | --- |
| Patient Name |  |
| Address |  |
| Date of birth |  |
| Ethnic status |  |
| Language spoken in household |  |
| Do you require an interpreter ? (please tick) | YES | NO |

|  |  |
| --- | --- |
| Next Of Kin |  |
| Phone Number |  |
| Other adults in the house |  |

|  |  |
| --- | --- |
| Current Medical problems |  |
| Medications |  |
| Allergies (please list) |  |

|  |  |  |
| --- | --- | --- |
| Immunisations up to date (please tick)\* | YES | NO |
| Child’s nursery or school |  |
| Support of other services (for example social work) |  |

\*If your child was vaccinated outside the UK please provide a copy of their childhood vaccines

**Due to new GDPR regulations we require written consent for someone else to collect your prescriptions. Please provide the names of anyone you give consent to collect your prescriptions below and then sign**

|  |
| --- |
| Sign Date |