LICHFIELD STREET SURGERY NEW PATIENT QUESTIONNAIRE
Age 13 or under

All information will be treated as confidential. We ask you to **FULLY** complete this questionnaire to ensure we have accurate details about your medical health should you require treatment prior to your records arriving from you old Doctor.

PLEASE RETURN COMPLETED FORMS TO RECEPTION BETWEEN 2PM & 4PM

Surname	Address
Forenames	
Telephone number (s) Mobile number: Email:	
Date of Birth	Postcode
Place of Birth	
Occupation: Name of School:	NHS number

PREVIOUS GP: Please state name and address

NEXT OF KIN: Please state name, relationship, address and telephone /mobile number

CARER: If you have a carer please state name, address and telephone number

MEDICAL HISTORY: Please list any serious illnesses, operations, accidents, disabilities (eg deafness, partially sighted etc.) with dates.

MEDICATION: Please list the names of all medications taken (including contraceptive pill)

ALLERGIES: Please list all known allergies to medications (eg penicillin)

ETHNICITY DATA:
The government and NHS require us to collect information on patients ethnicity when registering with the practice. We would be most grateful if you could tick the appropriate box

A: White

☐ British ☐ Irish
☐ Any other white background (please write in)……..

B: Mixed

☐ White and Black Caribbean ☐ White & Black African
☐ White and Asian
☐ Any other mixed background (please write in)……..

C: Asian or Asian British

☐ Indian ☐ Pakistani
☐ Bangladeshi
☐ Any other Asian Background (please write in)……..

D: Black or Black British

☐ Caribbean ☐ African
☐ Any other Black Background (please write in)……..

F: Chinese or other ethnic group

☐ Chinese
☐ Any other (please write in)……..
☐ **I do not want to disclose this information.**

First language: ……

APPLICATION TO JOIN THE PRACTICE PROCEDURE

1. Has the patient put their post code? Yes ☐ No ☐
2. Ensure all forms are fully completed and signed.
Check Ethnicity ☐ First language ☐ School ☐ Immunisation history
Incomplete forms cannot be accepted.
3. Has the patient presented with a birth certificate Yes ☐ No ☐
4. Does the parent / guardian understand about the SCR and care data Yes ☐ No ☐

Patient signature ……. Date: …….
Staff member …… Date: …….