38 Wentworth Avenue
Finchley
London
N3 1YL

Tel: 020 8346 1242

Wentworth GROUP PRACTICE

86 Audley Road
Hendon
London
NW4 3HB

Tel: 020 8203 5150

www.wentworthmedical.nhs.uk
wentworth.mp@nhs.net

Confidential New Patient Registration Questionnaire
Children's Questionnaire
(16 Years & Under)

PATIENT DETAILS:

Surname:…….. First Name(s)……..

Date of Birth:…… Sex: Male / Female

Home Address:…….....

Telephone Number(s):……

Consent to receive text messages via mobile re child: YES / NO

NHS Number:……

Previous GP: …… Practice Name:……

Previous Practice Address:…….....

Town and Country of Birth:……

Emergency Contact Name and Number:……

Parent(s)/Carer Name…….....

School/Nursery Name……..……...

Due to Child Protection guidelines, children will not be registered without a parent/guardian also being registered at the practice. A birth certificate will be asked for to confirm who has parental responsibility for a child.

Please confirm name/s of person/s with parental responsibility for registering child:

……

Do you consent for another adult (grandparent, au pair) to seek medical advice/treatment for your child: YES / NO

If yes, please provide names of persons to whom this consent applies and relationship to child:

……

Lifestyle

Height…… …… Weight…….. ……..

Child's Medical History

Has your child had the following Vaccinations, if so please state the date:

MMR **Date:** _____

MMR Booster **Date:** _____

Rubella **Date:** _____

Has your child had any of the following illnesses (please circle):

Measles Mumps German Measles Whooping Cough

Asthma Fits Chickenpox

Is there a history of fits/epilepsy in child's parents/brothers/sisters?

……..

Would you like patient Online access? (Please ask in reception)

Signature of parent/guardian:……

Please print name:…… Date:……

WE REQUIRE AN UP TO DATE IMMUNISATION HISTORY OF

CHILDREN UP TO THE AGE OF 6 UPON REGISTRATION

Please bring your red book to the surgery