# ISLANDHEALTH

L'Aumone - St Sampson's – Town

www.islandhealth.co.uk

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## New Patient Registration Form
(Under 16 year olds)

**PERSONAL DETAILS:**

Forenames:……………………..…………..…………Surname:……………………………………...Male/Female:……………..Date of Birth:…………………..

Place of Birth:……………………Nationality:…..………………Ethnicity:…………...….Address:…………………………………………………….………………

……………………………..………..…………..………………………….Post Code:…………… Name of School (if applicable):……………..............……………

GY Health Benefit No:…………........ Name of Previous GP:…………………………………… Name of Practice:………………..………..……………..

Full Name of Main Carer:…………………….…………….………Relationship with Child:….…………….….. First Language of Child/Carer:………....

Carer's previous address:……………………………………………………………………………………………………………………………………….....

Main Carer's Tel. nos. (Home)………….………..……(Work)…………….…....…….…(Mobile)……………...…...........………....

**PAST MEDICAL HISTORY:**

Birth Weight and any problems with birth……………………………………………………………………………………………………………

Any developmental problems…………………………………………………………………………………………………………………………

Please list any illnesses/operations………………………………………………………………………………………………………………...

Is the child allergic to medication (Yes No ) If Yes, which type of medication:………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………….

Does the child have any allergies(Yes ☐ No ☐) If Yes, list allergies:……… ……………………………………………………………………………

Please tick if the child suffers from Asthma ☐ Diabetes ☐ Epilepsy ☐

**FAMILY HISTORY** (are any of the child's closest family members affected by any of these conditions)

Glaucoma ☐ Blindness ☐ Tuberculosis ☐ Heart Disease ☐ Infectious Diseases ☐

Cancer ☐ (type of cancer if known)………………..………….. Other ☐ (please specify)……………………………………

Names of any Brothers or Sisters……………………………………………………………………………………………………..

**IMMUNISATIONS:** (Please supply this information if you have a record)

| | | |
|---|---|---|
| 1st DTP/Polio | 2nd DTP/Polio | 3rd DTP/Polio 1st Hib |
| 1st Hib | 2nd Hib | 3rd Hib |
| 1st Men C | 2nd Men C | 3rd Men C |
| Booster Hib | MMR | Pre School |
| Booster MMR | Others | |
| 1st Men B | 2nd Men B | 3rd Men B |
| 1st Pneumococcal (13) | 2nd Pneumococcal (13) | 3rd Pneumococcal (13) |
| 1st Rotarvirus | 2nd Rotarvirus | |

**Please use space over the page for any additional information** *(please add any other relevant information you think the Doctor should be aware of)*

## All of the above to be completed by Patient/Parent/Carer

**I understand that the Practice has the right to accept or decline this application. I agree to pay for all treatment given by the Practice at the time of treatment. Failure to do so may result in recovery of outstanding debt being passed on to a third party for recovery of the debt on the Practice's behalf. No medical information would be passed over to the third party recovery agent. I agree that the Practice may disclose personal details and details of medical records regarding both myself and my dependants to all those involved in providing me/them with healthcare and related services both inside and outside the Practice. I give my permission to the Practice to request information from my previous doctor and I agree to meet reasonable charges relating thereto.**

**Signed:………………………….. Date:………………………………..**

**UPON COMPLETION, PLEASE RETURN THIS FORM WITH FORMAL PHOTO ID TO EITHER OF THE SURGERIES BELOW**

**L'Aumone Surgery tel: 256517 St Sampson's Medical Centre tel: 245915 Town Surgery, Frances House tel: 724747**

For Office Use Only:
Received By:……………………. 9344…………….. Med Rec……………….. Scanned……………… Copy to A/c's:……………..
Date Received:…………………. Registered on Computer By:…………………. Registration Book:……………….. ID Copied:…….