ISLANDHEALTH

L’Aumone - St Sampson’s – Town

**www.islandhealth.co.uk**

**New Patient Registration Form**

(Under 16 year olds)

SEX: MALE / FEMALE / OTHER Patient No.........................

Forenames:……………………..………….........….....………Surname:……….....……………………………...:……………..Date of Birth:………....………..

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

………………………………….…………..…………………….........……Post Code:………..…… GY Health Benefit No. :……………................……………

Insurance Status (e.g.: BUPA, Foresters, Oddfellows, PPP, WPA etc.).............................................................. Insurance Scheme No.:.........................

WITH WHICH DOCTOR WOULD YOU LIKE TO BE REGISTERED?...................................................Name of Previous GP:………………………….….

Name and Address of Previous 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)……………...…............……....(Email)....................................................

**PAST MEDICAL HISTORY:**

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

Please list any illnesses / operations / medications……………………………………………………………………………………………………………………

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.**

**Please see IslandHealth’s Privacy Notice in relation to any of your data we may hold.**

**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:…….