COURT ROAD SURGERY

**CHILD NEW PATIENT QUESTIONNAIRE**

Patient Name:……………………………………………… DOB:…………………… Age ………

If registering new baby, Name of Mother …………………………………………………….

Home Tel No: ……………………………………..Mobile Tel No:…………………………………

Have you been registered here previously: No □ Yes □

Are you moving in/living with anyone who is already registered here?

No □

Yes □ **Please give name/s of person**……………………………………………………………....

If you do not speak **ENGLISH** please tell us your preferred language:

Welsh □ BSL □ Other- please specify ..................................

|  |  |
| --- | --- |
| Allergies: | |
| Weight: | Height: |
| School Attended  *(if applicable)* |  |
| In relation to this child is there input from an outside agency? | No □  Yes □ Social Worker  Yes □ Support Worker  Contact Details................................... |
| Do you look after anyone as a Carer? No □ Yes □  If yes, their name…………………………….. Relationship ……………………………………. | |

For Office Use Only

ID verified Birth Certificate viewed by .................................................