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 WorkerYes □ Support WorkerContact 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 .................................................