

COLCHESTER MEDICAL PRACTICE New Patient Child or Young Person Questionnaire

We encourage all our patients with home internet access or a connected smartphone to sign up to our Patient Access online service. You can book appointments, order repeat prescriptions and see a limited view of your medical records. Once they reach an age for consent this will be deactivated and they will have to bring in photographic ID for this to be reinstated *Tick here if you would not like to register for this service:*

The preferred method of communication with patients for Colchester Medical Practice is by letter or SMS, if you would prefer another method of communication please inform the Practice.

Surgery Details:	Date form completed:	
	NHS Number if known:	

Details of child being registered

Surname:	Forename(s):			
Date of Birth :	Sex: Male / Female			
First language spoken:	Religion:			
Ethnic origin:	Place of birth:			
Has the child been known by any other name : YES /NO If yes please give details:				

Details of Childs Main Carer:

Surname:	First Name:				
Current address (if different from child's):	Contact details (if different from above):				
What is your relationship to the child: (ie Mother, father - specify)	Consent to be contacted by text message Yes/No				
Does the child have contact with the Mother/ Father : YES / NO					
Surname:	First Name:				

Current address (if different to child's):	Contact details (if different to child)			
REGISTRATION FORM FOR CHILD OR YOUNG	5			
Any other significant carers involved in the upbr grandparent or Foster carer)	inging of this child or young person (eg Stepfather, aunt,			
If yes please give details:				
Are any other services known or involved with fa	amily or young person? Eg Social Care, Safeguarding			
Children/Adult , Looked after Children (LAC): YES / NO If yes, please give details :				
Does the child have any disabilities or distinguis				
If yes, please give details:	ning leatures ? YES / NO			
Please state any significant medical history :				
Is the patient on any repeat medication? YES / NO If yes please give details:				
Does the child suffer from any allergies? YES / NO				
If yes please give details:				
Is there any significant family history? ie. Asthma	a/Heart conditions			
Is the child or YP a smoker?: YES / NO	Does the child consume alcohol? YES / NO			
HOUSEHOLD COMPOSITION				

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Please list all persons (adults and children) who live at the address with this child							
Surname	First Name	DOB	Occupation/School /	Relationship to child ie.	Registered at surgery		
			Nursery	Sibling/Aunt etc	(Yes/No)		