Welcome to Parkhill and Sherwell Valley Medical Practice

For office use only

Comp no		GP / PN HCA		APPT DAY	DATE	TIME

REGISTRATION FORMS - CHILD UNDER 16 YEARS

Until your full medical records arrive this form acts as a temporary medical record.

Please answer all the questions below in capital letters.

Date / /

Have you been registered at this practice previously? **YES / NO**

Mr/Mrs/Miss/Ms …… Other …….. **Surname** ……

Forename(s) …… **D.O.B** ……

Address …….

Postcode…… **Tel No** …….

Height ...……... **Weight** …….

Next of Kin ……

Relationship …….. Tel no **.....**

Are you a smoker? YES / NO If yes how many a day? …….

Would you like help in quitting? YES / NO If yes please book a stop smoking appointment

Have any of your parents, brothers or sisters developed heart disease or had a stroke at an early age - (males <55 years, females <65 years) YES / NO

Is there a strong family history of

Diabetes YES / NO **Blood pressure problems** YES / NO **Cancer** YES / NO

Please detail, and think about talking to your GP about this ……...

Do you have any known allergies? YES / NO

(if yes please give details)…….....……

Are you a young carer. Do you look after someone? YES / NO

Does someone look after you? YES / NO

Would you like our Carer Support Worker to contact you? YES / NO

Medical History

Condition	Year of onset	Medication/Drugs	Strength	How often taken

SOME MEDICATION FOR NEW PATIENTS WILL INITIALLY BE CLASSED AS "ACUTE" AND WILL NOT SHOW ON YOUR REPEAT PRESCIPTION FORM BUT CAN STILL BE REQUESTED.

SPECIAL NEEDS – HELP US TO HELP YOU

Please tell us about any special needs that you have, so that we can try to accommodate them - for instance, if you cannot use the stairs, we can arrange to see you on the ground floor; if you are profoundly deaf, an interpreter can be arranged.

Do you have any sensory impairment?

Please tick appropriate box	YES	NO
Deafness		
Speech impairment		
Registered blind / partially sighted		
Do you have any specific cultural / religious needs?		
Do you need the services of a translator or interpreter?		
Do you have any phobias you would like us to be aware of? If yes please state:		

If you have already made an **'advance directive' (living will)** , then please make the medical staff aware and, ideally, bring a copy in when you next see your GP.

PATIENT ETHNIC ORIGIN / FIRST LANGUAGE QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission of Racial Equality and complies with the Race Relations Act.

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities and knowing your origins may help with the early identification of some of these conditions.

Choose **ONE** section from **A to E** and then tick **ONE** box to indicate your background.

Name: ..... Date of Birth: .....

A White

	British
	Irish
	Any other white background please write below

B Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other white background please write below

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background please write below

D Black or Black British

	Caribbean
	African
	White and Asian
	Any other black background please write below

E Chinese or other ethnic group

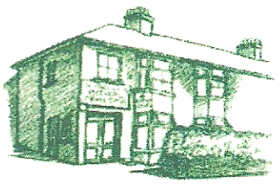
	White and Black Caribbean
	Any other please write below

Is your first language English? ☐ Yes ☐ No

If no, what is your first language? **.....**

PARKHILL
MEDICAL PRACTICE
Parkhill Road
Torquay, TQ1 2AR
Tel: 01803 212489
Fax: 01803 290603

Dr. Simon Murray
Dr. Roger Fearnley
Dr. Louise Anderson
Dr. Gordon Craig
Dr. Anisio Veloso
Dr. Wendy Bonn
Dr. Katherine Kennedy
Dr. Nicola Smales
Maldane Ltd.



SHERWELL VALLEY
MEDICAL PRACTICE
Sherwell Valley Road
Chelston, Torquay, TQ2 6EJ
Tel: 01803 605123
Fax: 01803 690250

Dear Parent / Guardian,

Welcome to Parkhill and Sherwell Valley Medical Practice.

Please complete the registration form and a new patient questionnaire for each child in **BLOCK CAPTIALS**.

Please return completed forms to reception **AFTER 11am** if possible. It can be busy earlier in the mornings and you may be asked to wait. A receptionist will need to go through the forms with you**.**
If your child is on medication we will make a new patient registration appointment with a GP. Please bring all your child's medication to this appointment, this is very helpful for the doctor.

Please note: Your child's **National Health Number** is required and can be obtained from your present surgery.

If your child was born outside the UK and are registering with a GP for the first time, **ALL** children under 16 years will be required to attend with **photographic proof of identification (e.g. passport or ID card).**

As part of the 2015 GP contact all Practices are required to provide their patients with a named GP who will have overall responsibility for the care and support that the Practice provides them. This is the GP whom you are registered with and you will be informed of this at the time of registering. This will not stop you from seeing any of the Doctors in the Practice and you are certainly not restricted to only seeing your named accountable GP.

Thank you.