Garswood Surgery New patient/Update records form
CHILDREN AGED 0 - 15

Childs Details

Patient's full name: Date of Birth:

Address:

Postcode:

E-Mail address: May we contact you by email? YES ☐ NO ☐

NHS Number (if known)

Telephone (Home): (Work): (Mobile):

May we contact you by text message? YES ☐ NO ☐ Detailed Text Messages ☐ Test Results ☐ Clinical advice or info ☐

Ethnic Group: Native Language : Religion:

CONTACT DETAILS FOR PARENTS/PERSON WITH PARENTAL RESPONSIBILITY

Mother's Name:

Mothers Address & Telephone Number (if different from above):

Are you a patient at Garswood Surgery? Yes ☐ No ☐

Fathers Name:

Fathers Address & Telephone Number (if different from above):

Are you a patient at Garswood Surgery? Yes ☐ No ☐

Name of person/people with parental responsibility (if different from above):

Does the person with parental responsibility live at the same address as above: YES ☐ NO ☐

If no, please give details below:

Are you a patient at Garswood Surgery? Yes ☐ No ☐

SCHOOL DETAILS

Name of School (if applicable):

Address of School:

School Telephone number:

Other information

Is the child under any other services: YES ☐ NO ☐
If yes, please provide details below :

Are you allergic to any medication? YES ☐ NO ☐

If Yes Please give details:

Accessible information Standards:- Does the child have any of the following medical diagnoses?

☐ Low vision ☐ Registered Blind ☐ Hearing problem adjusted with hearing aid ☐ Deaf ☐ Learning Difficulties
☐ Other condition where adjusted communication may be required (please state) _____

Do you require communications from the Practice to be sent to you in a specific format?
☐ large print ☐ Braille ☐ other (please state below) ☐ sent to relative/carers address (please provide forwarding address below)

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