**Cavendish Medical Practice**

[**www.cavendishmedicalpractice.co.uk**](http://www.cavendishmedicalpractice.co.uk)

**Registration Pack**

**Opening Hours:**

Monday to Friday

8:00am – 6:30pm

**Extended Opening Hours on Wednesday:**

6.30pm - 8.00pm

**Daytime Contact Number:**

0121 203 2050

**Outside Surgery Hours:**

0121 7662100

NHS 111

**Emergency Service:**

999

**Doctors:**

Dr T Cheema

Dr K Cheema

**Please bring your red book and Birth certificate**

**New Patient Questionnaire for Child under 18**

Name ……………………………………………………………………………… Date of Birth………………………………..

Country & City of Birth ………………………………………… Ethnicity………………………….. Language Spoken ………………..

Address ………….………………………………………………………………………………………………………………………………………..

Mother’s Name ……………………………………………………….Telephone number……………………………………………

Address Details (if different from Childs) ……………………………………………………………………………………………

Father’s Name ………………………………………………………….Telephone number…………………………………………..

Address Details (if different from child’s)……………………………………………………………………………………………

**Who has parental responsibility?** (Please circle one or both if applicable) Mother Father

Someone else (please state name and relationship to child)…………………………………………………………………

**Next of Kin (Emergency Contact- if different from above)**

Name: …………………………………………………………….

Address: ……………………………………………………………………………………………………………………………………………………….

Telephone (Home): ……………………Telephone (Work) : ……………….Telephone (Mobile): ………………………………

Are you happy for the surgery to contact this person in emergency? Yes / No

Does this person have legal power of attorney? Yes / No

**OTHER INFORMATION**

If your child is under 1 year of age: were they premature? Yes / No

Is your child home-schooled? Yes / No If No, which school do they attend? .......................................

Name of previous schools (if any): ………………………………………………………………………………………………………

Has your child ever been suspended (fixed-term exclusion) or permanently excluded from school? Yes / No

Name of Health Visitor/School Nurse/ Family Support Worker …………………………………………………...……………...

Is your child currently, or ever been, the subject of a Child Protection Plan or a Child in Need Plan? Yes / No.

If yes, when? ...............................

Is your child currently, or ever been, a “Looked After” child of “Child in Care” (i.e. in Foster Care or in a Children’s Home)? Yes / No

Is your child adopted? Yes / No

Any history of Female Genital Multilation (FGM) /cutting? Yes / No

**HOUSING:** What type of house does the child live in? (Please circle) Privately owned Council owned

House or flat (If flat which floor?) …………………………

Are there any housing problems? e.g. overcrowding, damp…………………………………………………………...

**HOUSEHOLD**

Please list all the people (children & adults) that share the house with the child and their relationship to them

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME OF PERSON** | **ADULT or CHILD (Please give age if under 18)** | **RELATIONSHIP TO CHILD** | **ARE THEY REGISTERED AT THIS PRACTICE?** |
|  |  | **MOTHER** | YES / NO |
|  |  | **FATHER** | YES / NO |
|  |  | **BROTHER / SISTER** | YES / NO |
|  |  |  | YES / NO |
|  |  |  | YES / NO |
|  |  |  | YES / NO |
|  |  |  | YES / NO |
|  |  |  | YES / NO |
|  |  |  | YES / NO |
|  |  |  | YES / NO |
|  |  |  | YES / NO |
|  |  |  | YES / NO |

Please also bring any / all Vaccinations history you may have (Redbook) or any other document/vaccination record from another country

**PLEASE CHECK THE FORM BEFORE SUBITTING**