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MEDICAL PARTNERSHIP
OUR STRENGTH IS IN OUR CARE
Incorporating; Lintonville Medical Group, Wellway Medical Group, Brockwell Medical Group

New Patient Questionnaire (Child)

When you register with us as a new patient, it would be helpful if you could provide evidence of your identification. This will help us to ensure we have the correct details, and can speed up the process of receiving your medical records from your previous surgery.

You can use the following documents:

- Passport
- Birth Certificate
- NHS Medical Card

We offer all children under 16 a New Patient Check. Please call Reception to make this appointment with the Practice Nurse within one month of joining the practice.

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New Patient Questionnaire (Child)

For Office Use Only
ID seen? YES / NO
Patient informed of registered GP? YES / NO

Name of Registered GP:
_____

Welcome to Lintonville Medical. Please complete this questionnaire as fully as possible. It gives us essential information about your health whilst we are awaiting your medical records.

Date: ……..
Surname: ……
Forename: ……
Name known as: ……
Date of birth: ……
Address: ……
……
……
Postcode: ……
Home telephone number: …… ☐
Mobile telephone number: …… ☐
(Please tick preferred contact number)
Email address: ……

Nominated pharmacy for collecting electronic prescriptions:	

If born outside of the UK, please states the date you first entered the UK?: ……

Have you ever served in the armed forces? YES / NO
If yes, are you happy for this to be coded on your medical records? YES / NO

Next of Kin

Should we need to contact you urgently, or in the event of an emergency, we would be grateful if you could provide us with the following details:

Next of Kin: Mr / Mrs / Ms / Other (please state) ……

Name: ……..
Relationship: ……..
Address: ……..
……..
Postcode: ……..
Telephone number (s): Home: ……..
Mobile:……

Non-prescribed Medication

Are you currently taking any medication which is NOT on prescription, e.g. that you buy from a chemist like Aspirin? YES / NO

If yes, please list below:

……
……

Important information about repeat medication.

If you are taking regular prescribed medication, you must provide us with a copy of your latest repeat medication list from your previous GP Surgery. This can be a recent prescription or a medication print-out from your previous GP. It is your responsibility to provide us with precise details of your regular medication as this will allow us to safely update your new patient medication records accordingly.

Have you attached / enclosed a printed copy of your repeat medication? YES / NO

Please note: If repeat medication information is not provided along with your new patient application this will delay your first request for medication.

Ethnicity – What is your ethnic origin? (please tick one box)

White British	□	Indian	□
Other white ethnic group	□	Pakistani	□
Black African	□	Other Asian ethnic group	□
Black British	□	Other ethnic group (please Specify)	
Black Caribbean / West Indies / Guyana	□		

Main spoken language: ……..
Do you need an interpreter: YES / NO

Smoking

I am a smoker □
(I smoke ……. per day)
I am an ex-smoker □
(Date stopped ……..)
I have never smoked □

Allergies

Are you allergic to anything (including medicines)? YES / NO

If yes, what are they:
…….....
……
……

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Patient Consent

This form will be scanned into your electronic patient record. This information will be used to help the practice provide you with complete and appropriate medical care.

If you leave the practice, this information will be transferred with your medical record to the new practice.

Please sign below to give your consent. If you do not sign to consent, a member of the practice will contact you to discuss your options.

Signature of Parent / Guardian: …..…….

Print: …..…….

Date: …..…….