

# NHS Family Doctor Services Registration

## CHILD REGISTRATION (5 and under)

*please complete in BLOCK CAPITALS and  as appropriate*

<b>Surname</b>		<b>First Name(s)</b>	<b>DOB:</b>
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<input type="checkbox"/> Master <input type="checkbox"/> Miss	<b>Home Address</b> <b>inc Post Code</b>
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<b>Town and Country of Birth:</b>	<b>Tel No:</b>
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**If coming from abroad - date you first came to live in the UK:**

**Previous address:**

**Previous GP:**

### If you are registering a child under 5

I wish the child above to be registered with the doctor named for Child Health Surveillance

**FIRST SPOKEN LANGUAGE WILL BE:**

**Patient Ethnic Questionnaire** 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. Please tick

<b>White</b>	British <input type="checkbox"/>	Irish <input type="checkbox"/>	Any other white background (please state)	
<b>Mixed</b>	White and Black Caribbean <input type="checkbox"/>	White and Black African <input type="checkbox"/>	Any other mixed background (please state)	
<b>Asian or Asian British</b>	Indian <input type="checkbox"/>	Pakistani <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Any other Asian background, (please state)
<b>Black or Black British</b>	Caribbean <input type="checkbox"/>	African <input type="checkbox"/>	White and Asian <input type="checkbox"/>	Any other Black background (please state)
<b>Chinese or Other Ethnic Group</b>	Chinese <input type="checkbox"/>			Any other (please state)

<b>Signature on behalf of Patient</b>	<b>Mum or Dad's Name:</b>
<b>Date</b>	<b>Date</b>

## TO BE COMPLETED BY THE DOCTOR

<b>Doctor's Name</b>	<b>HA Code</b>
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I have accepted this patient for general medical services  
 For the Provision of contraception service  
 I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

**Doctor's Name, if different from above** ..... **HA Code** .....

I am on the HA CHS list and will provide Child Health Surveillance to this patient OR  
 I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient

**Doctor's Name, if different from above** ..... **HA Code** .....

I will dispense medicines/appliances to this patient subject to health Authority's Approval  
 I am claiming rural practice payment for this patient. Distance in miles between my patient's home address and my main surgery is:

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

<b>DOCTOR'S SIGNATURE:</b>	<b>DATE:</b>
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