DARWEN HEALTHLINK
Dr. N Choudry, Dr. I M Derar,
Dr. S Jesthi & Dr. P Muzaffar
Tel: 01254 226600/226677
NEW PATIENT REGISTRATION FORM UNDER 16 YEARS

All information will be treated in the strictest confidence and is for your GP's records only

Surname/Last/Family Name:	Forename/First Name(s):	Previous Names: *
Address: Postcode:		
Date of Birth:	HAVE YOU BEEN REGISTERED WITH THIS PRACTICE BEFORE? **Yes** **No**	
Home Telephone Number:	Mobile Tel. Number:	Name of Parent if different from above
Name of School:		
Country of Origin/Ethnicity (*please circle*) **British or Mixed British- Irish – Other White background – White & Black Caribbean – White & Black African – White & Asian – Other Mixed Background – Indian or British Indian – Pakistani or British Pakistani – Bangladeshi or British Bangladeshi – Other Asian Background – Caribbean – African – Other Black Background – Chinese – Other Please State……**	**First Language**:	**Occupation**/ state retired occupation if applies:

Please tick one of the following as appropriate

FAMILY HISTORY Have you or your family had any of the following conditions?

	Yourself		**Your family** – Please state family member, eg mother, Brother, etc and give any relevant details
	Yes	**No**	
Asthma			
Diabetes			
High blood pressure			
Heart problems			
Stroke			
Epilepsy/fits			

Please list any MEDICATION allergies:

Have you had any illness/operations not mentioned above? *(Please give dates where applicable)*
Also state if you have any disabilities i.e. sight, hearing …

List of Current and Repeat Medication	

Please complete this section if the child registering is under the age of 5 years

Vaccinations	Please list all vaccinations completed in the boxes below (all information needed can be found in your **red book**)

Parent/Guardian signature: ……..

DATE:……

Thank you

FOR PRACTICE USE ONLY :

Member of staff who took registration form……..

Date……