FIRECLAY HEALTH
Your Health is Our Concern

New Patient Questionnaire for CHILDREN aged 0-15

Patient Details ***print clearly*** *and as* ***fully*** *as possible*	
Surname:	First name(s):
Date of Birth:	NHS no:

Contact Information*	
Contact Home Tel:	Contact Mobile no:
Contact Email:	
Name of person with parental responsibility: Relationship to child:	

To opt out of receiving text messages tick here ☐

***If you have provided an email address, we assume consent for contact by email. We assume consent to send texts to a mobile phone unless you have ticked the box to opt out. We will only text or email messages that are relevant to your ongoing healthcare, with the minimum of personal content. You are responsible for informing us of email address and phone number changes or if your mobile phone is lost or stolen. It is patient responsibility and to ensure contact details are updated to child's direct contact details at maturity.

What is your preferred method of communication from the practice? (please tick **ONE** box)

Mobile Tel (incl texts) ☐ Email ☐ Home Tel ☐ Letter ☐ No preference ☐

Young Carers

Does someone in your household rely on you for help? Yes ☐ No ☐

Please ask at Reception for a Carers Information Pack and a form to register with us as a carer

Ethnic Group (please tick **ONE** box)

White British ☐ Irish ☐ Other .....

Black Caribbean ☐ African ☐ Other .....

Asian Indian ☐ Pakistani ☐ Chinese ☐ Other .....

Mixed White + Black Caribbean ☐ White + Black African ☐ Other .....

Child's first language:
If this is not English, do you require an interpreter? Yes ☐ No ☐

Medical Information

Current medical conditions
Current medication *(please give strength and dosage if possible)*
Allergies to medicines or foods

Family History

Any serious illness particularly, heart disease, stroke, high blood pressure, diabetes, inherited diseases