



Registration Form For children under 16

Parents: Please complete this confidential registration form prior to your child's first consultation. Thank you.

Details

Surname:	Address:
First Name:	
Date of birth: / /	City:
Nationality:	Post Code:
Are you covered by private medical insurance?	Phone:
Name of Insurance:	Mobile:
	Email:

Do you have a NHS GP? yes no

If yes, please provide your details:	
GP name:	GP telephone number :
GP address:	Post code:

Would you like us to send reports of your child's private consultations to your NHS GP? yes no

Family history

Has anyone in your immediate family ever suffered from any of the following?

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Mental problems
<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Diabetes problems
<input type="checkbox"/> Any form of cancer	<input type="checkbox"/> Bowel problems

Birth history

Birth Weight: Complications during pregnancy? yes no If yes, provide details:

Was your child born prematurely? yes no If yes, how many weeks?

Admission to Special Care Baby Unit? yes no if yes, provide details:

Development – How old was your child when it was first

Sitting:

Crawling:

Walking:

Toilet trained:

Medical history

Has your child had/ does your child have:

If yes, please specify

-Congenital defects no yes

-Hip dysplasia no yes

-Development delays no yes

-Eye-problems no yes

-Ear problems no yes

-Skin problems no yes

-Seizures/convulsions: no yes

-Asthma: no yes

-Behavioural problems: no yes

-Any kind of cancer: no yes

-Any other illness: no yes

-Any allergies: no yes

-Immunisations :

- Diet

Does your child take any regular medication? no yes

Social History

Nursery / School: year/class

After School Care

I certify that the information given is correct:

Date:

Signature:

Where did you hear about us?

Maple Leaf Pharmacy/Clinic

Website, which?

Flyer

Advertisement

Personal recommendation

Other, please specify: