

**PATIENT REGISTRATION – INFANTS**

PLEASE COMPLETE ALL OF THE FOLLOWING DETAILS:

Child’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B: \_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any other family members already registered, or planning to register with Mountsandel Medical Centre? YES **□** NO **□**

**If yes, please list their full names and Date of Births below:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Is this the Registration of a New-born Baby? YES **□** NO **□**

Ethnicity **:** *(Please tick one box!)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| British |  | Other White |  | Bangladeshi |  |
| Black African |  | Black Carribean |  | Black Other Mixed |  |
| Chinese |  | Indian |  | Pakistani |  |
| Other (*please state)*: |  |  |  |  |  |

DO YOU REQUIRE THE SERVICES OF AN INTERPRETER? YES **□** NO

Preferred Language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Thank you for completing this Registration Form. Please return to Reception with Child’s Birth Certificate or Yellow Form.***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**For Office Use Only:**

**Date Received \_\_\_\_\_\_\_\_\_\_\_ Receptionist’s Name: \_\_\_\_\_\_\_\_\_\_\_\_**

**Registration Approved by GP (signed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**