The Health Centre, School Road, Kingskerswell, Devon TQ12 5DJ
The Health Centre, Silver Street, Ipplepen, Devon TQ12 5QA
Telephone: 01803 874455 Website: www.kkipp.GPsurgery.net

APPLICATION TO REGISTER A NEWBORN INFANT

PATIENT DETAILS Please complete in BLOCK CAPITALS and circle where appropriate

DO NOT FORGET TO BRING WITH YOU THE BIRTH CERTIFICATE AND A FORM OF PARENT/GUARDIAN ID

Mr Miss other		Surname:		
Date of Birth:		First names:		
NHS No:				
Male / Female		Town and country of birth:		
Home Address:				
Postcode:				
Mobile Telephone number:			Preferred Method of contact	**Mobile Email Landline**
Home Telephone No:				
Email Address:				

IPPLEPEN HEALTH CENTRE doctors will be able to dispense medicines/ appliances if you are able to say YES to one of these questions

I live more than 1 mile in a straight line from the nearest chemist	YES / NO
I would have serious difficulty in getting them from a chemist.	YES / NO

If you are registering a child under 5, do you wish the above child to be registered with the doctor for Child Health Surveillance?	YES / NO

YOUR ETHNICITY AND LANGUAGE

The NHS requires all medical records to show patients ethnic origin together with native or first language.

WHITE: British or Mixed British		ASIAN: Bangladeshi or British Bangladeshi	
WHITE: Irish		ASIAN: Any other background	
WHITE: Any other background		BLACK: Caribbean	
MIXED: White and Black Caribbean		BLACK: African	
MIXED: White and Black African		BLACK: Any other background	
MIXED: White and Asian		CHINESE:	
MIXED: Any other background		ANY OTHER ethnic group …………………………………	
ASIAN: Indian or British Indian		I prefer not to specify my ethnic group.	
ASIAN: Pakistani or British Pakistani			
What is your first spoken language?			

We will record your first spoken language as ENGLISH unless you specify otherwise.

YOUR FAMILY HEALTH HISTORY

Have your parents, brother(s) or sister(s) suffered from any of the problems listed below-
Please tick and then **circle which family member**

Diabetes (1252)		Father / Mother / Sister / Brother
Asthma (12D2)		Father / Mother / Sister / Brother
High Blood Pressure (12C1)		Father / Mother / Sister / Brother
Stroke (ZV171)		Father / Mother / Sister / Brother
Heart Disease (XE24Z)		Father / Mother / Sister / Brother

Name of parent	
Relationship	

Signature on behalf of child	Date

CHEMIST: Which chemist would you like your medication to be sent to?	

NEXT OF KIN

In order that you're GP can do all they can to help, it is important that they are aware of your next of kin. It would be helpful, therefore if you could provide the information requested below. A Next of Kin is usually is a close family relative or relatives. Patients are often asked to nominate a next of kin when registering with their GP or if you are admitted to hospital. The practice will not be able to share any clinical information with the next of kin without written consent of the patient concerned. *(Readcode 9182)*

Name:		Relationship to you:			
Address:					
Mobile		Landline		Email	
Permission to contact next of kin in an emergency	YES / NO (*please circle*)				

SIGNATURE OF PATIENT :	
OR SIGNATURE on behalf of a patient:	
DATE:	
Please note by signing this form you are consenting to receiving texts and emails from the practice	