Queens Park Medical Centre
Farrer Street, Stockton on Tees, TS18 2AW

Important Information for New Patients

The Practice will normally accept patients moving into the area and who do not have a doctor in the area, and patients who have close family members already registered with the Practice.

We require proof of identity and address before we can register you as a patient

This practice works by allocating patients to named doctors to enable both patient and doctor to get to know each other better; we believe this improves the quality of care we provide. Whenever possible this is the Doctor you will see should you require medical attention, although in urgent situations, or during the doctor's leave, we may ask you to see another doctor in the practice. However we do NOT allow transfers between doctors in the Practice.

We try to treat our patients in a polite and courteous manner and expect our patients to treat Doctors and Staff with the same level of respect. If you are unhappy with our arrangements you have the right to register with another practice.

The Practice operates a
ZERO TOLERANCE POLICY
If you are abusive to staff you will be asked to register with another practice.

In an average week 100 patients make and do not keep appointments. If you make an appointment and cannot keep it please let us know so we can offer the appointment to another patient. If you fail to keep an appointment on more than one occasion you may be asked to register with another practice.

Completion of this questionnaire does not guarantee your registration at the practice, it is your responsibility to contact the practice after 2 working days to confirm your registration and to find out which doctor you will be registered with.

Please answer the following questions, if necessary using the space overleaf to provide further details.

Section A

Parents Details

Title Mr / Mrs / Miss / Ms / Dr / Other

First Name ______________________

Surname ______________________

Previous Surname ______________________

Relationship to child ______________________

Childs Details

Title Mr / Mrs / Miss / Ms / Dr / Other

First Name ______________________

Surname ______________________

Previous Surname ______________________

Address ______________________

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Post Code ______________________

Date of Birth ______________________

	Can we contact you on these numbers & which is preferred			
Home Tel ______________		☐ yes	☐ no	☐ preferred
Mobile Tel ______________		☐ yes	☐ no	☐ preferred
Work Tel ______________		☐ yes	☐ no	☐ preferred

Email address ______________________

Marital status Married ☐ Single ☐ Divorce ☐ Widowed ☐ Other ☐

What sex were you assigned at birth? ☐ Male ☐ Female ☐ Decline

What is your current gender identity? ☐ Male ☐ Female ☐ Decline ☐ Transgender Male ☐ Transgender Female

Section B *(if applicable*

Previous GP Name ______________________

Previous GP Address ______________________

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Section C

Any known allergies? ______________________

Height ______________ Weight ______________

Section D

Is the child on any regular medication? Please list in the space provided below:

Section E

Have your parents or brothers / sisters had any of the following health problems?

Hypertension or raised blood pressure	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Heart attacks below the age of 60	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No

Section F

Has the child had the following immunisations?

Diptheria, Tetanus, Polio & HIB (given three times in first year)	☐ Yes	☐ No
Whooping Cough (given three times in first year)	☐ Yes	☐ No
Measles, Mumps & Rubella (given at age 1)	☐ Yes	☐ No
Pre school booster	☐ Yes	☐ No
Rubella (given to girls aged 10 or more)	☐ Yes	☐ No
BCG (given around 13)	☐ Yes	☐ No
School Leaving Booster	☐ Yes	☐ No
Has the child had any serious illness in the past	☐ Yes	☐ No
Does the child currently have any health problems	☐ Yes	☐ No

Section G

PATIENT ETHNIC ORIGIN QUESTIONNAIRE

- This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act
- Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

A.	**White:**	☐ British	☐ Irish	☐ Other	
B.	**Mixed:**	☐ White and Black Caribbean	☐ White and Black African	☐ White and Asian	☐ Other
C.	**Asian or Asian British:**	☐ Indian	☐ Pakistani	☐ Bangladeshi	☐ Other
D.	**Black or Black British:**	☐ Carribean	☐ African	☐ Black and Asian	☐ Other
E.	**Chinese or other Ethnic Group:**	☐ Chinese	☐ Other		

Section H

Further information

Please use this space for continuation or any other issues you feel your doctor will need to know about you.

Section I

Patient Declaration

To the best of my knowledge, all of the preceding answers and information provided are true and correct.

Signature

Print

Date

As a newly registered patient, you require a health check with a Practice Nurse. Please arrange for an appointment.

To acknowledge you have read and agree to these terms sign here.

Signed: ___________________________________ Date: ________________________

This information we hold about you as a patient can sometimes be shared with other bodies that are responsible for providing you with health care i.e Out of Hours services.

We will not share your information with anyone else without your express consent.

If you DO NOT want your information shared please sign below to indicate this as that you understand the implications of this request

Signed: __________________________________ Date: ________________________