New Patient Information Form – Child

Eye Health Centre

1. Background Details

Child's Details			
NHS Number	Don't know your NHS number? Visit www.nhs.uk/find-nhs-number		
Child Name		Gender	
Address		Date of Birth	
		Home Tel:	

Parent or Guardian Details			
Name		Relationship	
Address		Date of Birth	
		Home Tel:	
		*Mobile Tel:	
		**Email:	

*Do you consent to being contacted by SMS on this number? ☐ Yes ☐ No

**Do you consent to being contacted by email at this address? ☐ Yes ☐ No

It is your responsibility to keep us updated with any changes to your contact details. If your details change once you are registered, please let a member of the Reception team know or complete the *Change of Personal Details* form on our website.

Communication Needs	
What is your child's first language?	
Does your child have any communication needs?	☐ Yes ☐ No (if yes please specify below) ☐ Hearing Aid ☐ Lip Reading ☐ Large Print

2. Medical History

Medical History
Please indicate if your child has ever suffered from any of the following:
☐ Asthma ☐ Depression ☐ Diabetes ☐ Epilepsy Please add details of any other conditions:

Does your child have any allergies?
Please record below:

Current Medication		
Please list your child's current medication, including names, doses, and how often they take them:		
Medication	**Dose**	**Frequency**

You will need to provide us a repeat medication slip from your previous practice to order a repeat prescription from us for the first time

3. Further Details

Electronic Prescribing	
If you would like your child's prescriptions to be sent electronically to a pharmacy, please provide the details of the pharmacy you would like to use :	Pharmacy:

Parent or Guardian Signature	
Name	
Date	
Signature	I confirm that the information I have provided is true to the best of my knowledge