

**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 _____

Post Code _____ Date of Birth _____

Home Tel _____ Can we contact you yes no preferred

Mobile Tel _____ on these numbers & yes no preferred

Work Tel _____ which is preferred 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 _____

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?

Diphtheria, 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:** Caribbean 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