CHCP Practice

Newborn Baby
Registration Questionnaire

Patient Details	**Contact details of Parent(s) / Guardian(s)**
Forename: ……	Full Name of first contact: .....
Surname: ……	Relation: .....
Male / Female Date of Birth:__ __/__ __/__ __ __ __	Home Tel: .....
Address: ……	Mobile: ……
……	Work Tel: ……
Postcode:	**Is she/he the NEXT of Kin? YES / NO (please circle one)**
Home Tel: (01482)	- -
*** * * NHS No: __ __ __-__ __ __-__ __ __ __ * * ***	**Contact details of Parent(s) / Guardian(s)**
Please provide the baby's Discharge Paper issued at the hospital with NHS Number. Without the discharge paper we are unable to process the registration.	Full Name of second contact: .....
Parent / Guardian are requested to bring a form of Photo ID (Passport / Driving License) & Proof of Address.	Relation: .....
	Home Tel: .....
	Mobile: ……
	Work Tel: ……
	Is s/he the NEXT of Kin? YES / NO (please circle one)

Vaccination	**Any previous vaccinations given: YES ☐ NO ☐** **If yes please provide copies of any vaccinations given since birth.**

Patient Ethnicity, Language & Literacy (tick one)

☐	White British	☐	White Irish
☐	Other white ethnic group	☐	Pakistani
☐	Indian	☐	Bangladeshi
☐	Chinese	☐	Other Asian Ethnic Group
☐	Black African	☐	Black Caribbean/West Indian/Guyana
☐	Other black ethnic group	☐	Black African and white
☐	Other ethnic, Asian/white origin	☐	Black Caribbean and white
☐	Other ethnic group		

Country / Town of birth		**Religion**	
Main spoken language Spoken by Parent(s) / Guardian(s)	☐ Speaks English well ☐ Speaks English poorly Main Language spoken: ……		
Interpreter needed	☐ YES ☐ NO	**Using British sign language**	☐ YES ☐ NO

Disability Status	☐ YES	☐ NO	☐ DECLINED