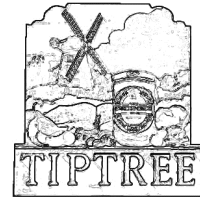


Tiptree Medical Centre
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Family
Healthcare

New Patient Registration Form - Children up to 18 years

Full Name:	
Date of Birth:	
Address:	
Post code:	
Tel Number:	Contact Number for Parent/Guardian:
Name of Parent/Guardian:	
Address of Parent/Guardian if Different from Child's (state relationship to child):	
Contact Number for Parent/Guardian:	

Does your child suffer from any ongoing illness?	Yes/No (please circle)
<i>If yes, please list:</i>	

Is your child currently taking any medication?

Yes/No (please circle)

If yes, please give details:

Is your child currently receiving hospital treatment?

Yes/No (please circle)

If yes, please give details:

Does your child have any allergies?

Yes/No (please circle)

If yes, please give details:

Does your child have any special communication needs such as language, sign language, braille, Yes/No (please circle)

If yes, please give details:

Are there any serious diseases that affect your family? *(tick all that apply)*

Diabetes

Heart attack

Heart attack under the age of 60

Cancer

High blood pressure

Asthma

Stroke

Thyroid disorder

Other *(please state)*