

REGISTRATION QUESTIONNAIRE – Under 16's

In order to provide you with good medical care, please complete the following questionnaire.

ALL THE INFORMATION ON IT IS COMPLETELY CONFIDENTIAL

Please be as accurate as you can with all the answers.

Have you previously been registered at either The Pontprennau Medical Centre?

Yes No

Are you on any repeat medication?

Yes No

If yes, please book an appointment for a health check with our practice pharmacist or healthcare assistant.

It is the custom of this Practice that all new patients are given a health check as part of their registration if they are on repeat medication. If you are on repeat medication please supply the practice with a copy of your repeat slip, which can be obtained from your previous surgery. If you do not provide the practice with a copy of your repeat slip there may be a delay in your medication being issued.

If your child is under the age of 5, please bring a copy of their 'red book' to the surgery with the completed forms.

Please specify any other group

What is your faith or religion, if any:

- Islam Sikhism Judaism Hinduism
Buddism Christianity (Anglican) Christianity (R.C.) Christianity (other)
Jehovah's witness None

Other please specify

FAMILY HISTORY

Have any members of your family (parents, grandparents, siblings) ever had any serious illness, e.g. heart disease, diabetes?

MEDICAL HISTORY

Do you have any physical disabilities that we should be made aware of?

PONTPRENAU MEDICAL CENTRE

Eligibility Form

- I am a permanent resident in the UK (Wales).
- I am an ordinary resident in the UK (Wales) for a settled purpose (work, study) for at least six months.
- I have formally applied for asylum in the UK and my application is still under consideration by the Home Office.
- I am a refugee who has been given leave to remain in the UK.
- I have an emergency problem which requires necessary treatment immediately. This would not include having forgotten medication.
- I am not eligible for NHS treatment and need to be seen as a private patient*.

*Charge £100 for ten minute consultation.

Please be aware that there will be a charge payable to the pharmacy for a private prescription and the medication.

I am applying for registration as a patient at this practice and I declare my eligibility as identified above.

I understand that if my declaration is later found to be false, I may forfeit my right to treatment at this practice and may be liable for the cost of the treatment.

Signed: _____

Date: _____

(If child – signature of parent or guardian)