BINFIELD SURGERY

NEW BABY QUESTIONNAIRE

SURNAME: ______________________________ FIRST NAME: _______________________________

ADDRESS: ____

__________________________ POSTCODE: _________ OCCUPATION: _________________________

DATE OF BIRTH: ___________ Male/Female: ______ PLACE OF BIRTH: _________________________

TEL NO: Day _________________ Evening __________________ Mobile ______________________

EMAIL ADDRESS: ____

Which Ethnic group does your child belong to?

White British – Irish Other	☐	Black or Black British African – Caribbean Any other Black Background	☐	Mixed White & Black Caribbean White & Black African White & Black Asian Any other mixed background	☐
Chinese Or any other Ethnic group	☐	Asian or Asian British Bangladesh – Indian - Pakistan any other Asian background	☐	Not stated (9iG)	☐

ADDITIONAL INFORMATION

Would you like your child's prescriptions sent electronically? Yes/No

If yes, please add name of Pharmacy here.

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Are you happy for us to use SMS text service to remind you of your child's appointment?
Yes or No

Are you happy for us to use SMS to communicate clinical messages? Yes or No

Please sign for consent ____