High Street Surgery

219 High Street
Hornchurch
Essex
RM11 3XT
Tel: 0170 844 7747
Fax: 0170 845 1408

Please complete this form for any child (up to age 6) registering with your practice; and return completed forms to the above address – Thank you.

TODAY'S DATE: _____

CHILD'S N.H.S NUMBER

CHILD'S SURNAME_____DATE OF BIRTH ___/___/___

CHILD'S FORENAMES_____SEX_____

ADDRESS _____ &
TELEPHONE_____

CURRENT DOCTOR'S
NAME AND ADDRESS_____

DOCTOR'S IDENTIFYING NUMBER (if known)
Or SURGERY ADDRESS

DETAILS OF THE CHILD'S PREVIOUS IMMUNISATIONS:- (Particularly helpful if the child has recently moved into this area)

_____

CHILD'S PREVIOUS ADDRESS: _____
(or previous country if from abroad)

CHILD'S PREVIOUS G.P. _____

Thank you for completing this form

For more information about the services we offer, please refer to your new patient pack or visit our surgery website at http://www.highstreetsurgery.co.uk/.