QUEENS ROAD MEDICAL PRACTICE

Accredited by CHKS Insight for better healthcare

**FOR OFFICE USE ONLY**
**To be completed when forms returned & checked**

**Staff Initials:** _____
**Date:** _____

# New Birth Application Form

**Please fill in this form in BLOCK CAPITALS**

| **BABY'S DETAILS** | |
|---|---|
| **Forename(s)** | |
| **Preferred Name (if not Forename)** | |
| **Surname** | |
| **Date of Birth** | |
| **Ethnicity** | |
| **Home Address** | |
| **Postcode** | |

| **SOCIAL SECURITY** | | |
|---|---|---|
| **GY Number** | **GY** | |
| GY numbers allow you eligibility for the Health Benefit Grant. For more information, please visit www.gov.gg/socialsecurity<br>If you do not have a GY number, you will have to access Pathology, Radiology, Pharmacy and Secondary Care Referrals privately.<br>If you have not provided a GY number – please complete the below field: | | |
| Applied for GY number? | **Yes** ☐ | **No (Private)** ☐ |

| **FAMILY DETAILS** | |
|---|---|
| **PARENT 1** | |
| **Forename(s)** | |
| **Surname** | |
| **Relationship to Child** | |
| **Contact Numbers** | Mobile:<br>Home: |
| **Email Address** | |

*Appointment reminders are sent to the mobile number/email provided for 'Parent 1'*
*If you do **NOT** want to receive reminders via text or email, please tick here* ☐

| **PARENT 2** | |
|---|---|
| **Forename(s)** | |
| **Surname** | |
| **Relationship to Child** | |
| **Contact Numbers** | Mobile:<br>Home: |
| **Email Address** | |

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## FAMILY HISTORY

Do you or your child's siblings have any of the following? (**P**-Parent, **S**-Sibling)

| | Yes | Who? | | Yes | Who? |
|---|---|---|---|---|---|
| Diabetes | ☐ | | Heart attack | ☐ | |
| Asthma | ☐ | | Bowel Cancer | ☐ | |
| High blood pressure | ☐ | | Breast Cancer | ☐ | |
| Epilepsy | ☐ | | Ovarian Cancer | ☐ | |
| Family history not known | ☐ | | | | |
| Any other condition | | | | | |

## INSURANCE DETAILS

| | |
|---|---|
| **Insurance Company** | |
| **Policy Details** | Policy Number:<br>Customer Number:<br>Start Date: |

**Insurance Coverage Disclosure:**

By proceeding with treatment, the patient confirms that they have independently verified their insurance coverage for the services requested. It is the patient's sole responsibility to confirm with their insurance provider whether the proposed treatment(s) are covered, including any applicable co-pays, deductibles, or limitations.

Queens Road Medical Practice LLP operates under the assumption that this confirmation has been completed prior to scheduling or receiving care. We are not responsible for any denial of claims, partial reimbursements, or unexpected out-of-pocket expenses resulting from lack of insurance coverage. Any balance not covered by the patient's insurance remains the responsibility of the patient.

## DECLARATION BY PARENT/GUARDIAN

I understand that the Practice has the right to accept or decline this application.

I agree to pay for all treatment given to my child by the Practice.
*(Full details of our pricing are available from reception or on our website at www.qrmp.gg)*

I agree that the Practice may disclose personal details and details of medical records regarding my child to all those involved in providing healthcare and related services both inside and outside the Practice.

**To be signed by a parent or guardian**

| | | | |
|---|---|---|---|
| **Print Name** | | **Relationship to Child** | |
| **Signed** | | **Dated** | |

**Please return this form with a copy of your child's BIRTH CERTIFICATE to the Practice**

Your details will be stored and used as per our Privacy Notice; This can be viewed on our website and is also available upon request at reception.

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**To be completed when clinical system updated**

**Staff Initials:** _____
**Date:** _____