

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	

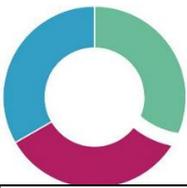
SOCIAL SECURITY	
GY Number	GY
<p>GY numbers allow you eligibility for the Health Benefit Grant. For more information, please visit www.gov.gg/socialsecurity</p> <p>If you do not have a GY number, you will have to access Pathology, Radiology, Pharmacy and Secondary Care Referrals privately.</p> <p>If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

FAMILY DETAILS	
PARENT 1	
Forename(s)	
Surname	
Relationship to Child	
Contact Numbers	Mobile: 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: Home:
Email Address	



FAMILY HISTORY

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

	Yes	Who?		Yes	Who?
Diabetes	<input type="checkbox"/>		Heart attack	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>		Bowel Cancer	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>		Breast Cancer	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>		Ovarian Cancer	<input type="checkbox"/>	
Family history not known	<input type="checkbox"/>				
Any other condition					

INSURANCE DETAILS

Insurance Company	
Policy Details	Policy Number: Customer Number: 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.

<p>FOR OFFICE USE ONLY To be completed when clinical system updated</p> <p>Staff Initials: _____ Date: _____</p>
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