New patient registration - Child

SUNSTATE FAMILY PRACTICE

OFFICE USE ONLY
ENTERED_____
SCANNED_____
DOCTOR_____

PERSONAL INFORMATION					
TITLE:	SURNAME:		FIRST NAME:		
MIDDLE NAME:		PREFERRED NAME:			
Date of Birth:		Sex: ☐ Male ☐ Female ☐ Other			
I **DO** identify as ☐ Aboriginal ☐ Torres Strait Islander ☐ Both (please tick if applicable)					
What is your racial background or ethnicity? i.e Australian, English, Chinese _____ With what other religion or cultural group do you identify? (if any) _____ Do you require a translator/interpreter service for your appointment? ☐ Yes					
Residential Address					
Postal Address					
Phone Numbers	M: Home: Work:				
Contact via (best no.)	☐ Mobile ☐ Home ☐ Work				
Email address					
Please tick if you do NOT wish to receive the following electronic reminders/messages via SMS ☐ Reminders ☐ Recalls and results ☐ Health Information					
☐ Please tick if you do NOT wish to have your Individual Health Identifier No. verified to enable My Health Record access					
Medicare No.		Ref No.		Expiry	
Pension Card No.				Expiry	
Health Care Card No.				Expiry	
D.V.A. No.				Expiry	
Private Health	☐ Yes ☐ No				
Next of Kin (N.O.K)					
Contact No. (N.O.K)		Relationship			
Emergency Contact					
Emergency Contact No.		Relationship			
Alternate Contact Person					
Alternate Contact No.		Relationship			
How did you first hear about our practice? ☐ Website ☐ Facebook ☐ Family or Friend ☐ Redland City Bulletin ☐ Other (please state)					

MEDICAL HISTORY

FULL NAME:	D.O.B.	☐ Nurse entered (Initial)

ALLERGIES

Does your child have any allergies? ☐ Yes ☐ No If yes, please list below

Allergen	Reaction & severity

MEDICATIONS

Is your child currently taking any medications? ☐ Yes ☐ No If yes, please list below

Medication	Dose/Frequency	Reason

Is your child taking any other medicines? (natural medicine, vitamins, herbal remedies) ☐ Yes ☐ No
Please list:_____

MEDICAL HISTORY

Does your child have any previous medical conditions ☐ Yes ☐ No If yes, please list below

Condition	Date

SURGICAL HISTORY

Does your child have a history of surgical procedures? ☐ Yes ☐ No If yes, please list below

Procedure	Date and location performed

DEVELOPMENTAL HISTORY

Does your child have any emotional or psychological developmental conditions?
If yes, please list below

Condition	Date

STAFF TO COMPLETE

HT: **WT:** **Waist:** **HR:** **BP:**

FAMILY HISTORY

Is there any relevant family medical history not mentioned above? ☐ Yes ☐ No If yes, please list below: _____

_____

PREGNANCY

Was this child born prematurely If yes, how early was he/she born

→

Were there any complications during pregnancy? ☐ Yes ☐ No If yes, please provide details below

→

Were there any complications during birth? ☐ Yes ☐ No If yes, please provide details below

→

IMMUNISATION HISTORY

Birth	☐ Yes ☐ No	4 years	☐ Yes ☐ No
2 months	☐ Yes ☐ No	Grade 7	☐ Yes ☐ No
4 months	☐ Yes ☐ No	Grade 10	☐ Yes ☐ No
6 months	☐ Yes ☐ No	Meningococcal (15-19 years)	☐ Yes ☐ No
12 months	☐ Yes ☐ No	Influenza	☐ Yes ☐ No
18 months	☐ Yes ☐ No		

FAMILY ARRANGEMENTS

Is there currently a custody arrangement in place for this child? ☐ Yes ☐ No If so please explain below.

HEALTH INFORMATION COLLECTION AND USE CONSENT

To enable ongoing care and total quality improvement within this practice, and in keeping with the Privacy Act 1988 and National Privacy Principles, we wish to provide you with sufficient information on how your personal health information may be used or disclosed and record your consent or restrictions to this consent.

Your personal health information will only be used for the purposes for which it was collected, or as otherwise permitted by law and we respect your right to determine how your personal health information is used or disclosed.

The information we collect may be collected by a number of different methods and examples may include: medical test results, notes from consultations, Medicare and health insurance details, data collected from observations and conversations with you, and details obtained from other health care providers (e.g. specialist correspondence).

By signing below, you (as a patient/guardian) are consenting, that on obtaining your personal health information it may be used or disclosed by the practice for the following purposes:

- Follow up reminder/recall notices for treatment and preventive healthcare.
- For accounting procedures and the collection of professional fees.
- The diagnosis and treatment of any health condition, including the communication of relevant information only, to practice staff, specialists and other healthcare providers to ensure quality care is provided.
- Accreditation and Quality Assurance activities are conducted by professionally trained non-treating GP's and other professionally trained and qualified persons e.g. General Practice Managers.
- For legal related disclosure as required by a court of law.
- For the purposes of research only where de identified information is used.
- To allow medical students and staff to participate in medical training/teaching using only de identified information.
- For disease notification as required by law.
- For use when seeking treatment by other doctors in this practice.

I acknowledge there may be a need to contact me, & I permit the use of the telephone numbers provided by me. By providing these contact numbers, I accept that a message may be left with the person answering these numbers, or on a message service attached to these numbers.

At all times, we are required to ensure your details are treated with the utmost confidentiality. Your records are very important and we will take all steps necessary to ensure they remain confidential.

Patient Name: _____ give my permission for my personal health information to be collected, used and disclosed as described above. I understand only my relevant personal health information will be provided to allow the above actions to be undertaken and I am free to withdraw, alter or restrict my consent at any time by notifying this practice in writing.

Signature: _____ Date: _____

If not Patient signing – Your Name (Please Print)_____

Your relationship to patient (e.g. Mother, Father, guardian)_____