Your Doctors ™
Randwick

Child

Patient Details

Your NAME should be written as on your Medicare Card

TITLE	*FIRST NAME*	*PREFERRED NAME* *(If different to First Name)*	*FAMILY NAME*	*DATE OF BIRTH*	*GENDER*

ADDRESS	*CONTACT DETAILS*
Home Address _____	**Home** _____
Suburb/Town _____ **Postcode** _____	**Work** _____
Postal Address _____	**Mobile** _____
Suburb/Town _____ **Postcode** _____	**Email** _____ **(PLEASE PRINT CLEARLY)**

We will use this email address to keep you updated about health happenings at the practice unless you tick this box. ☐
We will send SMS reminders for some types of appointments: Are you happy for us to use your mobile number for this purpose? ☐ **yes** ☐ **no**

MEDICARE NUMBER **LINE NUMBER** **MEDICARE NUMBER** **EXPIRY DATE**

PENSION/CONCESSION HEALTH CARD No _____ **Expiry Date**_____

VETERANS CARD No _____ **Card Colour** _____ **Expiry Date** _____

NEXT OF KIN	**PERSON TO CONTACT IN CASE OF EMERGENCY**
Name _____	**Name** _____
Contact Phone No _____	**Contact Phone No** _____
Relationship _____	**Relationship** _____
Is this person an existing patient? YES / NO	**Is this person an existing patient? YES / NO**

ETHNIC / CULTURAL BACKGROUND
☐ ABORIGINAL
☐ TORRES STRAIT
☐ OTHER, please state _____

Where did you hear about Your Doctors?	
☐ From a friend	☐ You live in the area
☐ From another medical professional	☐ Yellow Pages
☐ Other:_____	

Your Doctors Randwick Patient Consent for use of Personal Health Information

a) Within the practice

I, (your name) _____ give permission for my child's medical records and personal health information to be shared between doctors of this practice. I understand that all doctors and staff of this practice are covered by confidentiality agreements. I also understand that should I not want any part of the medical or personal information disclosed to other doctors or staff of this practice, I need to inform my usual doctor of this issue.

b) Outside the practice

Furthermore, I agree to allow my doctor to communicate relevant medical details to specialist doctors, [such as hospitals, pathology labs, and other health care providers e.g. physiotherapists, podiatrists], etc. involved in my medical care.

c) For Dependants

As guardian/parent of the above named child I authorise that their health information be also used in the above mentioned manner.

This practice from time to time participates in medical research projects with outside organisations. We stress that all information shared is **depersonalised** (i.e. names of patients are **NOT** given). If you expressly DO NOT want any of your clinical information used in this manner, please indicate with a cross in the following box ☐
The practice will from time to time send out reminders for various health checks. If you DO NOT wish to receive these reminders please tick the following box ☐

Your Signature – Patient/ Parent/ Guardian ➔ _____ Date _____

Name of Witness _____ Signature of Witness _____

CHILD CLINICAL DETAILS

Child's Name: _____ **Date of Birth:** / /

Name of Parent 1: _____ **Name of Parent 2:** _____

Home Phone: _____ **Parent 1 Mobile:** _____ **Parent 2 Mobile:** _____

PRIOR HEALTH SUMMARY

Please list any complications with regard to the pregnancy, labour and birth of your child.

_____

_____

Does your child have any serious illnesses? (yes/no)
If yes, please list_____

_____

Has your child had any stays in hospital and/or any past operations? (yes/no)
If yes, please list_____

_____

_____

Does your child see any specialist/s regularly? (yes/no)
If yes, please list_____

_____

Does your child take any regular medication? (yes/no)
If yes, please list_____

_____

Does your child have any allergies? (yes/no)
If yes, please list_____

_____

IMMUNISATION

Are there any comments you wish to make regarding immunisation? _____

_____

_____

Please list your child's family members' state of health:

Parents: _____
Siblings: _____
Grandparents: _____

Some illnesses occur more frequently amongst certain ethnic groups, help us tailor your child's care by identifying your child's cultural background. Please feel free to tick more than one box if this applies.

- ☐ Aboriginal from _____
- ☐ Torres Strait Islander from _____
- ☐ Pacific Islander from _____
- ☐ European from _____
- ☐ Asian from_____
- ☐ American from_____
- ☐ African from_____
- ☐ Other, please state_____
- ☐ Unknown