CASEYMEDICALCENTRE

☐ DR TO INITIAL

New Patient Information Form (CHILD < 16yr)

We are committed to providing our patients with the best care. To do this it is essential that your medical records are up to date and accurate. Could you please assist us by completing the following?

CONSENT FOR CONTACT ☐ YES ☐ NO

A/c No: **Doctor:** **Date**	**Surname**	**First Name**
Address		
Phone Number	H)	M)
Date of Birth	**Male**	**Female** **Other**
Medicare number **Healthcare/Pension Number**		
Parent / Guardian (Name, Relationship, Phone Number and Address.)		
Emergency Contact Details (If different to Parent / Guardian)		

To assist with health initiatives – Does your child identify as being of Aboriginal and/or Torres Strait Islander descent?

☐ Yes ☐ No

Place of Birth - _____Cultural Background/Ethnicity_____

Does your child have Refugee status? Yes ☐ No ☐

Health History - Does your child have?

☐ Medical Problems_____

_____

In the past has your child had?

☐ Medical Problems/ Past Operations_____

_____

Is your child on any medications? Please list below, with doses:

_____

_____

Does your child have any allergies or are they sensitive to any medications or dressings?

☐ Yes (If yes please list below) ☐ No

_____

Children's Immunisations - Are your child's immunisations up to date? ☐ Yes ☐ No

Family History - Have any members of the child's family had any of the following?

☐ Diabetes_____ ☐ Asthma_____

☐ Heart Disease_____ ☐ Mental illness_____

☐ Cancer_____

☐ Other_____

Reminder Systems:

- The practice routinely sends SMS appointment reminders as well as for recalls and test results.
- Please tick the box if you are happy to receive SMS (mobile text messages): ☐ **Yes** ☐ **No**