Your Doctors®

Patient Details

Child

Your NAME should be written as on your Medicare Card

TITLE	*FIRST NAME*	*PREFERRED NAME*	*SURNAME*	*DATE OF BIRTH*	*SEX*	
					M	F

ADDRESS

Street ______________________ **Home** ______________________

Suburb/Town ______________ **Postcode** ________ **Work** ______________________

Email ______________________ **Mobile** ______________________

(PLEASE PRINT CLEARLY)

MEDICARE NUMBER LINE NUMBER ☐ MEDICARE NUMBER ☐☐☐☐☐☐☐☐☐☐ EXPIRY DATE ☐

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

PENSION/CONCESSION HEALTH CARD No ______________________ **Expiry Date** ____________

VETERANS CARD No ______________________ **Expiry Date** ____________ **RECORD No:** ________

PERSON TO CONTACT IN CASE OF EMERGENCY

1. Name ______________________ **Relationship** ______________

Contact Phone No ______________________ **Is this person an existing patient? YES / NO**

2. Name ______________________ **Relationship** ______________

Contact Phone 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 Patient Consent for use of Personal Health Information

a) Within the practice

I, (your name) ______________ give permission for my 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 my 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, hospital medical staff, pathology labs, and other health care providers e.g. physiotherapists, podiatrists, etc. involved in my medical care.

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 ☐

c) For Dependants

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

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