WEST BRUNSWICK CLINIC
Your health care team

Doctor	

New Patient Registration Form - Child - 1-15 Years of Age

Surname			Gender	Male Female Other		
First Name			Middle name			
Preferred name			Date of birth			
Unit/Street number		Street name				
Suburb				Postcode		
Postal address						
Parent - Name						
Mobile			Work Ph			
Home Ph		Preferred Contact		Mobile	Work	Home
Email address						
Parent Name						
Mobile			Work Ph			
Home Ph		Preferred Contact		Mobile	Work	Home
Email address						
Legal guardian	Name					
(if applicable)	Telephone		Relationship			
Medicare number			Ref #	Exp date		
Concession/Healthcare card #				Exp date		

To assist with health initiatives are you: Aboriginal or Torres Strait Islander? (please circle)

NO **YES - Aboriginal & Torres Strait Islander** **YES** - Aboriginal **YES** - Torres Strait Islander

Nationality/Culture		Country of Birth	
Preferred language		Do you require an Interpreter?	YES NO

Communications Consent
I consent to receive SMS messages as ticked below

Appointments ☐ Clinical Reminders ☐ Clinical Communications eg reca test results ☐ Health Awareness eg W information ☐

For further information please refer to our communication policy on our website at www.wbc.com.au

Privacy: Your medical record is a confidential document. It is the policy of this practice to maintain security of personal health information at all times in accordance with privacy laws, and to ensure that this information about how the practice handles your record is available to you upon request. Our practice undertakes professional development and quality assurance improvement activities to improve patient care.
We use a reminder system to improve the quality of your health care and send out reminders for vaccinations, pap tests & other reviews.

I acknowledge that information provided on this registration form is true and accurate.

Name of parent/guardian			
Signature of parent/guardian		**Date**	/ /

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Medical History - Child - 1-15 Years of age

Birth/Pregnancy Details: please tick or write details as appropriate				Single		Multiple	
Pregnancy?							
Was the gestation?	Premature		Or within 2 weeks of due date				
Details (if applicable):							
Any pregnancy complications, for mother or baby?				**YES (please list)**		NO	
Any Medical problems with your child after birth?				**YES (please detail):**		NO	
Does your child have any allergies?				**YES (please list)**		NO	
Medications:							
Food:							
Other:							
Has your child had any operations?				**YES (please detail)**		NO	
Is your child on any regular medications, supplements or vitamins?				**YES**		NO	
Has your child been immunised?	FULLY		PARTLY		NOT IMMUNISED		
Any additional immunisations ie. for travel?							
Do you have any family history of significant medical conditions? Ie. Diabetes, Cancer, Coeliac Disease, Heart Conditions, Asthma etc. (please indicate who in the family has the condition)							