WEST BRUNSWICK CLINIC
Your health care team

Doctor	

New Patient Registration Form - Newborn - Under 12 Months 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 recall 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**	/ /

WEST BRUNSWICK CLINIC
Your health care team

Medical History - Newborn - under 12 Months of Age

Name of Hospital where baby was born					
Birth/Pregnancy Details: please tick or write details as appropriate	Single		Multiple		

Pregnancy details:

Was the gestation?	Full term		Premature		If prem, by how much?		
Any pregnancy complications, for mother or baby?			**YES (please list)**			NO	

Please tick:

Natural conception		Assisted		Ferility			
Vaginal delivery		Caesarean		Forceps		Vacuum	

Any problems at the time of labour/delivery?	**YES (provide details)**		NO
Any Medical problems with your child after birth?	**YES (please list)**		NO
Does your child have any allergies?	**YES (please list)**		NO
Medications:			
Food:			
Other:			
Has your child had any operations?	**YES (provide details)**		NO
Is your child on any regular medications, supplements or vitamins?	**YES**		NO
Did the child receive the birth vitamin K & hepatitis B doses?	**YES**		NO
Has the child had any further immunisations?	**YES**		NO
If YES, list by age given ie. 2, 4, 6 month:			
Is the child currently breast or bottle fed?	Breast	Bottle	
Any further information you would like to provide:			