WEST BRUNSWICK CLINIC

Your health care team

Dr	

Title (please tick)	☐ Master ☐ Miss ☐ Mx ☐ Other:		
Gender (please tick)	☐ Male ☐ Female ☐ Non-Binary ☐ Other:		
Pronouns	☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Ze/Zir/Zirs		
Surname			
First Name		**Middle Name**	
Preferred Name		**Date of Birth**	
Address			
Suburb		**Postcode**	
Postal Address			
Parent 1 - Name			
Mobile		**Work Phone**	
Home Phone		**Preferred Contact**	☐ M ☐ H ☐ W
Email Address		*Relationship*	
Parent 2 - Name			
Mobile		**Work Phone**	
Home Phone		**Preferred Contact**	☐ M ☐ H ☐ W
Email Address		*Relationship*	
Legal Guardian (if applicable)	*Name*		
	Telephone	*Relationship*	
Medicare Number		*Ref #*	*Expiry Date*
Pension/HCC Card #		*Expiry Date*	
Card Type (please tick)	☐ Pensioner Concession ☐ Healthcare Card ☐ Commonwealth Seniors Card		
To assist with health initiatives are you: Aboriginal or Torres Strait Islander? ☐ 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 ☐ Health Awareness eg Wellness Information

For further information, please refer to our ommunciation policy on our website at www.wbc.net.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.

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

Name of Parent/Guardian			
Signature of Parent/Guardian		***Date***	

Medical History

Birth/Pregnancy Details: ☐ Single ☐ Multiple	
Was gestation: ☐ Within 2 weeks ☐ Premature - by how long? Please state:	
Please list details & any complications for mother or baby	
Any medical problems with your child after birth? ☐ Yes ☐ No	
Allergies	
Medication:	
Food:	
Other:	
Has your child had any operations? ☐ Yes ☐ 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 i.e. for travel?	

Condition	☐	**Who & Details**	**Condition**	☐	**Who & Details**
Heart Disease	☐		***Diabetes***	☐	
Respiratory Disease	☐		***Kidney Disease***	☐	
Asthma	☐		***Cancer***	☐	
Other Family History (please list if applicable)					

Other Information/Conditions