WEST BRUNSWICK CLINIC
Your health care team

Dr	

Birth Sex *(please tick)*	☐ Male ☐ Female ☐ Other:		
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*
Health Care Card #			*Expiry Date*

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

Name of hospital where baby was born:				
Pregnancy/Birth Details:	☐ Single	☐ Multiple		
	☐ Natural Conception	☐ Assisted		
	☐ Vaginal Delivery	☐ Caesarean	☐ Forceps	☐ Vacuum
Was gestation:	☐ Within 2 weeks	☐ Premature - by how long? Please state:		
Please list any complications for mother and/or baby				
Any problems at the time of labour/delivery?	☐ Yes - please provide details	☐ No		
Any medical problems with your child after birth?	☐ Yes - please list	☐ No		

Allergies
Medication:
Food:
Other:

Has your child had any operations?	☐ Yes - please provide details	☐ No

Is your child on any regular medications, supplements or vitamins?	☐ Yes	☐ No

Did the child receive the birth vitamin K and hepatitis B doses?	☐ Yes	☐ No
Has the child had any further immunisations?	☐ Yes	☐ No

If YES, please tick which are relevant:	☐ 6-8 weeks	☐ 2 month	☐ 4 month	☐ 6 month

Is the child currently breast or bottle fed?	☐ Bottle	☐ Breast

Other Information/Conditions