NEW PATIENT REGISTRATION FORM – CHILD UNDER 17 YEARS

PartridgeGP

Doctor:

Appointment Time/Date:

To be completed with child's details

Title:	·Mr ·Miss					
Family name:						
Given name:	**Middle Name:**					
Preferred name:						
Date of Birth:						
Sex:	·Male ·Female ·Other		**Gender Identity:**		·Male ·Female ·Other	
Preferred Pronouns:	☐ He/Him/His		☐ She/Her/Hers		☐ They/Them/Their	
Ethnicity:	·Australian	·Aboriginal	·TSI	·Aboriginal *and* TSI		
	·Other Ethnic Background (please advise)					
Address (Residential):						
Address (Postal):						
Phone:	Patient's mobile:					
	Parent/Guardian mobile: SMS Reminders?: ·Yes ·No					
E-mail:						
Medicare No.:	Ref No: Exp:					
Health Care Card:	No.: Exp:					
Occupation:						

CONTACT DETAILS OF CHILD'S PARENT / GUARDIAN

· I am a patient of the Practice and my name is _____ please use the details you already have on file.

If you are not a current patient at our Practice - please provide your details below:

Name		D.O.B.	
Medicare Number	Ref No: Expiry:		
Relationship to Child			
Please complete below if your details are different to the child's			
Address			
Phone Numbers	H	M	W
Email address			

NEW PATIENT REGISTRATION FORM – CHILD UNDER 17 YEARS

Are you the Emergency contact for the child? · Yes · No *if No please provide details below

If no, please list an alternative Emergency name and phone number:

Phone Numbers	H	M	W

Please list current medications the child takes: (including vitamins and mineral supplements)

Please list any allergies the child has:

IMMUNISATIONS (please tick relevant boxes)

· Pneumococcal (pneumonia) · Influenza · Tetanus
· Childhood vaccines up to date · other (please specify)

Please list any medical history and past surgery/operations/previous significant illnesses or injuries

Is there a family history of (please circle)

Diabetes	Heart Disease	Stroke	Asthma
Cancer	Please specify which kind:		

Privacy

In accordance with the *Privacy Act (1988),* all information collected in this practice is treated as "sensitive information". To protect your privacy, this practice operates in accordance with the Act. We use the information you provide to manage your health care. You can assist in maintaining the accuracy of your information by advising the practice of changes of address, phone number etc.
Selected information may be disclosed to various other health services involved in supporting your health care management, (e.g. Pathology & Radiology)

Please Note – Due to privacy laws it is preferred that adults and over sixteens arrange their own appointments whenever possible. Results cannot be given to a third party except under special circumstances.

· **I understand that as the parent or guardian of this child, I am responsible for the payment of their account on the day and I give permission for any results to be communicated with me on their behalf.**

Parent/Guardian Signature: - …… Date: …… /…… /……..

NEW PATIENT REGISTRATION FORM – CHILD UNDER 17 YEARS

Health Information Collection and Use - Consent Form

PartridgeGP, 670 Anzac Highway Glenelg SA 5045

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur though referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

I have read the information above and understand the reasons why my information must be collected.	☐
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me.	☐
I am aware of my rights to access the information collected about me, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	☐
I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.	☐
I consent to the handling of my information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice. **Or** I am unsure and would like to discuss this further with someone from the medical practice before I sign.	☐ ☐
I understand that PartridgeGP has the right to charge a nonattendance fee or a late cancellation fee. I understand that I am required to give 24 hours' notice to cancel an appointment.	☐

Patient's name: _____ **Date:** _____/_____ / **20** _____

Signed as Guardian for Child: _____ **Guardian Name:** _____