



## NEW PATIENT REGISTRATION FORM – CHILD

### SECTION A – PERSONAL DETAILS

<b>Title</b>	<b>Family name</b>	<b>First name</b>	<b>Middle name</b>	<b>Preferred name</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>D.O.B</b>	<input type="text"/>	<b>Birth Sex</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other	<input type="checkbox"/> Unknown
<b>Gender Identity</b>	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Gender Diverse <input type="checkbox"/> Transgender <input type="checkbox"/> Other			
<b>Pronouns</b>	<input type="checkbox"/> She/Her/Hers <input type="checkbox"/> He/Him/His <input type="checkbox"/> They/Them/Theirs			
<b>Ethnicity</b>	<input type="checkbox"/> Australian, non-indigenous <input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both Aboriginal & Torres Strait Islander			
<b>Other cultural background (e.g., Mediterranean, Asian, African)</b>	<input type="text"/>			
<b>Country of Birth</b>	<input type="text"/>			
<b>Is English your first language?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Do you require an interpreter?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Please specify language</b>
				<input type="text"/>
<b>Home address</b>	<input type="text"/>			<b>Postcode</b>
				<input type="text"/>
<b>Postal address</b>	<input type="text"/>			<b>Postcode</b>
				<input type="text"/>
<b>Home phone</b>	<input type="text"/>	<b>Mobile phone</b>	<input type="text"/>	<b>Work phone</b>
<input type="text"/>				
<b>Email</b>	<input type="text"/>			
<b>Medicare card number</b>	<input type="text"/>	<b>Reference number</b>	<input type="text"/>	<b>Expiry date</b>
<input type="text"/>				
<b>Pensioner concession card</b>	<input type="text"/>	<b>Expiry date</b>	<input type="text"/>	
<input type="text"/>				
<b>Health Care card</b>	<input type="text"/>	<b>Expiry date</b>	<input type="text"/>	
<input type="text"/>				
<b>Veteran's Affairs card</b>	<input type="text"/>	<b>Type</b>	<input type="text"/>	
<input type="text"/>				
<b>Next of kin</b>	<input type="text"/>	<b>Relationship</b>	<input type="text"/>	
		<b>Phone</b>	<input type="text"/>	
<b>Emergency contact</b>	<input type="text"/>	<b>Relationship</b>	<input type="text"/>	
		<b>Phone</b>	<input type="text"/>	
<b>Your occupation (if applicable)</b>	<input type="text"/>			



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### SECTION B – CONSENT

Our practice uses a reminder system to help you maintain your health. The practice sends reminders by post, email, telephone, or SMS for procedures such as vaccinations, cervical screening tests (Pap test) and other health reviews.

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| I consent to receiving appointment reminders via SMS     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| I consent to receiving clinical reminders via SMS        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| I consent to being contacted with clinical communication | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| I consent to receiving health awareness information      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Are we able to leave a confidential message for you regarding results, recall, or confirming/changing appointments?  
(please circle your preference)

Mobile Yes|No

Home Yes|No

Work Yes|No

I authorise the following person to take messages regarding a recall, reminder or change of appointment on my behalf:

Name  Relationship   
Phone

- I have been given a copy of 'Westside Medical Centre Practice Information' sheet (take time to read)
- I understand that Westside Medical Centre is NOT a bulk-billing practice.  
Payment is required on the day of consult. If you hold a current Pension Card you will be bulk-billed.

### Privacy

It is always the policy of this practice to maintain the security of personal health information and to ensure that this information is only available to authorised members of staff. Patient information may have to be disclosed to other doctors, nurses, and medical technicians so that proper health care is not compromised. You can assist in maintaining the accuracy of your information by advising the practice of any changes to your personal contact details.


Is there a Parenting Order in place for this patient?  Yes  No

If so, please provide details below

I hereby declare that the information provided is true and correct.

Signature of patient or guardian

Date



Print name

THANK YOU