GPA

Tweed Coast Medical

New Patient Form - CHILD Date: _____

Please circle…… Mast Miss

Family Name _____ First Name _____

Preferred Name _____ Date of Birth _____

To assist with health initiatives – is your child of Aboriginal or Torres Strait Islander origin?

□ No □ Yes □ Aboriginal □ Torres Strait Islander □ Other _____

Country of Birth? _____

Address: _____Suburb: _____

Postcode: _____ Home Phone: _____ Mobile: _____

Parent/Carer email address: _____

Medicare Card number: _____ Ref. on card _____ Expiry Date:_____

Pension Card No. _____ Expiry Date:_____

Healthcare Card No. (Concession Card) _____ Expiry date:_____

Next of Kin Name: _____Phone: _____Relationship to child: _____

Emergency Contact Name: _____Phone: _____ Relationship to child:_____

Cancellations: If you are unable to attend an appointment we ask that you contact the surgery as soon as possible so that we may offer the appointment to another patient. Non-attendance and failure to advise the surgery may result in a $30 fee.

Information and Consent

We value your privacy. All information about your child at Tweed Coast Medical is kept in the strictest confidence and we operate in accordance with the Privacy Act (1988). Please refer to our privacy pamphlet for information.

In our practice, we have a recall and reminder system for our patients. We will contact you (parent/carer) either by phone, letter or sms for reminders and test result recalls and for ongoing patient care.

Please mark the boxes below if you consent to receiving sms appointment reminders for your child and sms clinical reminders and communication. We may also send out occasional Health Awareness emails and Practice Information which you can opt out of at any time.

☐ Consent for sms appointment reminders ☐ Consent for sms Clinical Communication (Results and Clinical Messages)

☐ Consent for sms Clinical Reminders ☐ Consent for Health Awareness / Practice Information emails

I also consent to the use of and disclosure of my child's personal health information to any health care provider involved in his/her medical treatment and health care.

Signed: _____

Name _____ **Relationship to Child** _____

Tweed Coast Medical

Patient Medical History Form

Name: _____ DOB: _____ Date: _____

IT IS IMPORTANT FOR YOUR CHILDS ONGOING HEALTH TO COMPLETE THE FOLLOWING QUESTIONS.

Does your child have any allergies or is sensitive to drugs or dressings?

☐ Yes (If yes please list below) ☐ No

Children's immunisations – Are all immunisations up to date?

☐ Yes ☐ No

Current Health – Does your child have any of the following conditions?

☐ Asthma ☐ Diabetes ☐ Mental Health Concerns ☐ Cancer ☐ Heart Disease

☐ Any Past Operations?

Current medications including over the counter vitamins and supplements:

Family History – Have any family members had;

☐ Diabetes Who: …….. ☐ Asthma Who: ……..

☐ Heart Disease Who: …… ☐ Cancer Who: ……..