Tweed Health for Everyone

Child New Patient Information Form

The following information will assist in the planning and provision of appropriate and improved healthcare and services so that we can provider the best care possible.

PLEASE NOTE DRUGS OF DEPENDENCE WILL NOT BE PRESCRIBED ON YOUR INITIAL CONSULTATION

Title: Surname:		Given Name:
Known as:		Date of Birth:
Nationality:	Birth Sex (please circle) M F	Gender Identity:

Do you identify as being: (Please circle)

Aboriginal Origin | Torres Straight Islander Origin | Both Aboriginal and Torres Straight Islander Origin | Neither

Other Cultural Group, please state:

Residential Address: _____

Home Phone:	Work:	Mobile:
Email Address:		

Medicare Number:	Ref Number:	Exp Date:
Pension/Health CC Number (please circle):		Exp Date:

DVA Number:	Gold or White Card (please circle)

Details of your **NEXT OF KIN**

Name:	Relationship to patient:	
Address:		
Home Phone:	Work:	Mobile:

Details of your **EMERGENCY CONTACT** Person

Name:	Relationship to patient:	
Address:		
Home Phone:	Work:	Mobile:

PATIENT CONSENT

I consent to the use of and the disclosure of my personal health information to any health care provider involved in my medical treatment and health care, including MyHealth Record and de-identified data for research.

As a part of preventative health services offered by this practice we send out follow up reminders and recalls when routine investigations are due. I consent to receive the following via sms/email:

☐ Appointments reminders ☐ Clinical Communication (results & reminders)

☐ Health Awareness (demographic specific promotions) ☐ Consent to email Invoices

By consenting to receive sms reminders I understand that other users of the mobile phone number I have provided may be able to gain access to appointment/clinical reminders sent by Tweed Health

Registered by Mother/Father/Other (Please circle)

Mother's Name: _____ Father's Name: _____

Signature: _____ Date: _____

Name: _____

Allergies

Does your child have any allergies or sensitivities to drugs or dressings? (Please Circle)

NO	YES (please specify)

Medical Conditions (Past and Present)

Operations (please include the year)

Medications (Current Medications including over the counter medication & Supplements)

Medication	Strength	Quantity per day

Family Medical History (e.g. cancer, heart disease, diabetes, asthma, melanoma etc.)

Birth History

Was your child born at full term (38 weeks +)
Any complications during the pregnancy or birth?:

Vaccinations

Has your child had the following vaccinations? (please circle)

Birth (Hep B)	Yes / No	12 Months	Yes / No
2 Months	Yes / No	18 Months	Yes / No
4 Months	Yes / No	4 Years	Yes / No
6 Months	Yes / No	Other?	Yes / No

Social

How many siblings:
Does your child attend daycare or school? If yes, which grade?
Has your child had any delay in development?
Does your child have any hearing of vision problems?