Melbourne Developmental & Behavioural Paediatrics

PATIENT REGISTRATION FORM

Suite 4/90 ▪ Mitcham Rd ▪ Donvale VIC 3111
Ph: (03) 9841 9388 ▪ Fx: (03) 9841 7860 ▪ Em: admin@mdbp.com.au
Web: www.mdbpaediatrics.com.au

(BLOCK LETTERS PLEASE)

1. PATIENT DETAILS

First Name: Preferred Name:		School/Preschool:
Surname:	No & Street:	
D O B:	Suburb:	Year Level:
Age:	State:	Teacher:
Sex: M / F	Postcode:	School Phone:
Medicare Card Number:	Number on Card:	Valid To:

2. PARENT / GUARDIAN DETAILS

MOTHER / GUARDIAN	FATHER / GUARDIAN
First Name:	First Name:
Surname:	Surname:
No. & Street:	No. & Street:
Suburb:	Suburb:
State: Postcode:	State: Postcode:
Occupation:	Occupation:
Phone (Hm): (Mob):	Phone (Hm): (Mob):
Email:	Email:
Medicare Card No:	Medicare Card No:
Card Valid To: DOB:	Card Valid To: DOB:

3. MEDICAL HISTORY

Born at ……. weeks gestation	Normal Delivery: Y / N	Caesarean Delivery Y / N
Birth Weight:	Apgar Scores: &	Smiled at ……. weeks
Sat up at ……. months	Crawled at ……. months	Walked at ……. months
Babbled at ……. months	Spoke first word at ……. months	Immunisations Up-to-Date: Y / N
Hearing last checked: / /	Current medications:	
Vision last checked: / /		

CHILD'S MEDICAL HISTORY: (Including during pregnancy)

FAMILY'S MEDICAL HISTORY: (Please list any parents, cousins, uncles/aunties or grandparents who have a history of mental illness, heart issues, asthma, intellectual disabilities, Aspergers, Autism, etc.)

CURRENT CONCERNS:

Privacy Information and Consent

We require your consent to collect personal information about you and your child. Please read the following information about privacy issues, practice requirements and fees carefully, and sign where indicated below.

This medical practice collects information from you regarding your child for the primary purpose of providing quality health care. We require you to provide us with you and your child's personal details and medical history so that we may properly assess, diagnose, treat and be proactive in your child's health care needs. This means we will use the information you provide in the following ways:

- Administration purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your child's health care, including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in reports or results returned to us following the referrals.
- Disclosure to other doctors in the practice, locums, medical students and by Registrars attached to the practice for the purpose of patient care and teaching.
- We may also need to communicate with teachers, allied health providers and other professionals involved with your child. Please let us know if you do not want your records accessed for these purposes. This will be noted accordingly.
- In an emergency situation where it is in the best interest of your child's health care we would disclose appropriate information if requested to do so.

Parent/Guardian Acknowledgement

I have read the information above and understand the reasons why this information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to my child.

I am aware of my right to access the information collected about my child, except in some circumstances where access might legitimately be withheld. I understand 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 this practice for the purposes set out above, subject to any limitation on access or disclosure that I notify the practice of.

I agree to abide by the following practice procedures:

- It is my responsibility to make sure I have a current referral from my G.P. for each visit
- If I fail to attend an appointment and/or do not give more than 24 hours notice of my cancellation, I may be charged a non-attendance fee of $100
- My child must be in attendance at all appointments (If not, a Medicare rebate is not claimable)
- Patient xrays will be destroyed if they have not been collected more than 2 years after the date of service

I understand that the cost of consultation is above the Medicare schedule fee, which means that I will incur an out of pocket expense. I agree to pay the full account at the time of consultation.

I have read this form before signing it and a member of staff has, at my request, clarified aspects of it that I have not understood.

NAME OF PATIENT…….....NAME OF PARENT/GUARDIAN……

SIGNATURE OF PARENT/GUARDIAN .....DATE: ...../...../.....