Patient Registration

Melbourne Developmental & Behavioural Paediatrics
Leading the way...

Patient Details

First Name:	Surname:	School or Preschool:
Preferred Name:	No & Street:	
Date of Birth:	Suburb:	
Gender:	State: Postcode:	Year Level:
Medicare Card Number:	Reference Number:	Valid To:

Parent / Guardian Details

Parent / Guardian 1 (Account Payer? Y / N)	Parent / Guardian 2 (Account Payer? Y / N)
First Name:	First Name:
Surname:	Surname:
Relationship to Patient:	Relationship to Patient:
No. & Street:	No. & Street:
Suburb: State: Postcode:	Suburb: State: Postcode:
Occupation:	Occupation:
Phone (Mob): (Landline):	Phone (Mob): (Landline):
Email:	Email:
Medicare Card No: Ref No:	Medicare Card No: Ref No:
Valid To: / DOB:	Valid To: / DOB:

Family Structure, Care and Legal Status

Family Structure: ☐ Intact ☐ Separated ☐ Other: ____________________

Third party (DHS, Anglicare, etc) involved in the care or custodianship of the patient? Y / N

Organisation:____________________ Contact Name: ____________________ Role: ____________

Address: ____ Phone: ____________

COURT ORDERS? Y / N Details:

Medical History

Born at .... weeks	Normal Delivery: Y / N	Caesarean: 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: / /	Vision last checked: / /	

Child's Medical History: (Including during pregnancy and current medications:)

Family Medical History: (Relatives with a history of intellectual disabilities, Aspergers, Autism, ADHD, etc.)

Current Concerns:

PTO

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 you and 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 and/or disclose the information you provide for the following purposes:

- For administration purposes in running our medical practice
- For billing purposes including compliance with Medicare and Health Insurance Commission requirements
- 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.)
- To other doctors within the practice, locums and medical students attached to the practice for the purpose of patient care and teaching
- To teachers, allied health providers and other professionals involved with the care of your child
- To other appropriate people in an emergency situation, where it is in the best interest of your child's health

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 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 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 legally 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 than set out above my further consent will be obtained.

I consent to be communicated with via SMS regarding appointment schedules.

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
- 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 any aspects of it that I have not understood.

NAME OF PATIENT :... NAME OF PARENT/ GUARDIAN :......................................
(PLEASE CIRCLE)

SIGNATURE OF PARENT/GUARDIAN:.. DATE: ..../......./............
(PLEASE CIRCLE)