



NEW PATIENT REGISTRATION FORM

(CHILD AND ADOLESCENT)

Bridging Healthcare Pty Ltd

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This registration form is used for all children and adolescents aged 14 and younger. We need this information to provide the best quality care. This form complies with the RACGP *Standards for General Practices (5th ed)*, meaning your personal health information is kept private and secure, as required by federal and state privacy laws. If you have concerns, please leave blank and discuss with your nurse practitioner.

Please notify us promptly of any changes in your contact details. Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about tests and results.

SECTION A: CHILD/ADOLESCENT DETAILS

Title	Surname	Given Names	
Preferred Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> Non-Binary	
Address			City/Suburb
Postcode	<input type="checkbox"/> Mobile	<input type="checkbox"/> Home	
Email			
Medicare Card Number <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> Expiry <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			

PARENT/LEGAL GUARDIAN DETAILS

Name	Relationship	
Best Contact Number: <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work	Date of Birth	

WHO CAN WE CONTACT IN AN EMERGENCY?

Name	Relationship	
Best Contact Number: <input type="checkbox"/> Mobile <input type="checkbox"/> Home <input type="checkbox"/> Work	<input type="checkbox"/> Same contact as above.	

Do you want us to upload relevant information to the child/adolescent's MyHealth Record?

Yes – with my consent. No I would like more information about this.

Do you want us to upload any vaccinations the child/adolescent receives to the Australian Immunisation Register?

Yes – with my consent. No I would like more information about this.

How did you hear about us?

Google Facebook Pharmacy Staff Friend/Family Friend/Family Signage
 Other _____

SECTION B: CULTURAL BACKGROUND

Knowing the child/adolescent's cultural background can help us provide healthcare that meets their individual needs.

Are they of Aboriginal and/or Torres Strait Islander origin?

No Aboriginal Torres Strait Islander Prefer not to say

Other cultural background (e.g. Mediterranean, Asian, African)	Country of Birth
Is English their first language? <input type="checkbox"/> Yes <input type="checkbox"/> No	Language(s) spoken at home:
Do they require an interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION C: ALLERGIES AND MEDICINES

List any allergies to medicines or intolerances they have:	Describe their reaction:
<input type="checkbox"/> The child/adolescent has no known allergies to medicines.	
List any regular medicines they take, along with doses (if known). Include herbal or vitamin products.	
<input type="checkbox"/> The child/adolescent does not take any regular medicines.	

SECTION D: MEDICAL HISTORY

Please tick any relevant past medical history relevant to the child/adolescent:

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Cancer | <input type="checkbox"/> Learning Difficulties |
| <input type="checkbox"/> Premature | <input type="checkbox"/> Migraines | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Mental Health Issue |

SECTION E: DEVELOPMENTAL HISTORY

Are all childhood vaccinations up to date? Yes No

Are there any smokers in the household? Yes No

Do you have any concerns about the child/adolescent's development? Yes No

SECTION F: CONSENT

Bridging Healthcare uses a reminder system to help you maintain your child/adolescent's health. The clinic sends reminders by email, post or SMS for reminder procedures like vaccinations and other health reviews they need. By signing below, you consent to being contacted for reminders relating to the planning and managing of their health. By signing below, you consent to the child's de-identified health information to be shared for the purposes of service improvement and research activities that provide insight into and improve community health and health services management.

Parent/Guardian Name (Printed) _____ Signature _____ Date _____