NEW PATIENT REGISTRATION FORM

(CHILD AND ADOLESCENT)

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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** ☐ Male ☐ Female ☐ Intersex ☐ Non-Binary
Address		**City/Suburb**
Postcode	☐ **Mobile**	☐ **Home**
Email		
Medicare Card Number ☐☐☐☐☐☐☐☐☐☐ / ☐ **Expiry** ☐☐ / ☐☐☐☐		

PARENT/LEGAL GUARDIAN DETAILS

Name	**Relationship**
Best Contact Number: ☐ **Mobile** ☐ **Home** ☐ **Work**	**Date of Birth**

WHO CAN WE CONTACT IN AN EMERGENCY?

Name	**Relationship**
Best Contact Number: ☐ **Mobile** ☐ **Home** ☐ **Work**	☐ 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_____

- Please Complete Other Side of this Form -

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? ☐ Yes ☐ No	**Language(s) spoken at home:**
Do they require an interpreter? ☐ Yes ☐ No	

SECTION C: ALLERGIES AND MEDICINES

List any allergies to medicines or intolerances they have:	**Describe their reaction:**
☐ 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.	
☐ 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:

☐ Heart Problems
☐ Developmental Delay
☐ Premature
☐ Anaemia
☐ Diabetes
☐ Cancer
☐ Migraines
☐ Asthma
☐ Eczema
☐ Learning Difficulties
☐ Epilepsy or Seizures
☐ 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**_____