Total Health Pottsville – Child (<16yrs) patient information form

Thank you for assisting us by completing the following 2 pages for your child:

Surname **Pronouns (please circle)**	**Mr Mrs Ms Miss Master Birth M / F Gender M / F / Other** **She / Her / Hers He / Him / His They / Them / Theirs**		
First & Second Names	**Preferred Name**		
Date of Birth			
Address			
Postal address **(If different to above)**			
Telephone Numbers	**Home: Mobile: Work:**		
Medicare Number		**Ref #**	**Expiry Date**
Pension card number			**Expiry Date**
Health care card number			**Expiry Date**
Next of kin	**Name:** **Relationship to child:**		**Phone number:** **Address:**
Emergency Contact Person (if different to above)	**Name:** **Relationship to child:**		**Phone number:** **Address:**
What is your child's ethnicity/family heritage/place of birth?			
Does your child identify as Aboriginal or Torres Strait Islander?	**Aboriginal** **Torres Strait Islander** **Other**		**Both Aboriginal & TSI** **Neither Aboriginal nor TSI**

We contact patients by SMS text message/phone and/or send out recall letters for test results and for ongoing patient care. Doctors at Total Health Pottsville are required to participate in research for quality assurance. To enable us to do this, we need permission to use de-identified medical information from patient's medical records. Please sign below to give permission for your child to be included in our recall system, and to give permission for your child's de-identified medical data to be used for research and quality improvement purposes.

Signature:..... **Date:**.....

The **confidentiality of information** contained within this document is protected & will not be used for any purpose other than to create a medical record as well as to keep your medical records up to date.

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***PATIENT NAME*:** .....

Age: ..... **Height:** ..... cm **Weight:** ..... kg

Does your child have any ALLERGIES or sensitivities to medications, dressings or foods? (please circle)

- No
- Yes - Please specify .....

Are your child's vaccinations complete for their age, according to the Australian National Immunisation Program? (please circle)

- Yes
- No - Please elaborate .....

Does your child have any medical problems? (please circle)

- Asthma
- Eczema or dermatitis
- Hay fever
- Frequent ear infections
- Other .....

Does your child take any medications regularly?

(including over the counter medications, vitamins and minerals):

.....

Has your child ever been to hospital because of a medical problem or for an operation?

- No
- Yes - Please elaborate .....

Does your child's parents or siblings have any medical problems?

- Mother .....
- Father .....
- Siblings .....

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