PIVOTAL health

New Patient Information Form - Child

We are committed to providing our patients with the best care. To do this it is essential that your child's health record is kept up to date and is accurate.

Could you please assist us by completing the following information	
Title	☐ Master ☐ Miss
Surname	
Given Name/s	
Date of Birth	
Country of Birth	
Street Address	
Postal Address (if different than above)	
Home Phone Number	
Work Phone Number	
Mobile Phone Number	
Do you consent to receiving text messages?	☐ Yes ☐ No
Email Address	
Do you consent to receiving emails?	☐ Yes ☐ No
Does your child have an electronic My Health Record?	☐ Yes ☐ No
If no, are you interested in finding out more about creating a My Health Record?	☐ Yes ☐ No
To assist with health initiatives – do you identify as Aboriginal or Torres Strait Islander:	☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, Aboriginal and Torres Strait Islander

Medicare Number and Reference Number (the number beside your name)	Card No. __ __ __ __ __ __ __ __ __ __/ __ Expiry Date:
Pension Number	Card Number: Expiry Date:
Private Health Cover	☐ Yes ☐ No ☐ Hospital ☐ Extras Name of Fund:
How did you find out about our practice?	

Parent/ Guardian Details	
Parent/Guardian 1	
Title	☐ Miss ☐ Mrs ☐ Ms ☐ Dr
Surname	
Given Name/s	
Contact Phone Number	
Relationship to Child	
Marital Status	☐ Married ☐ Single ☐ DeFacto ☐ Separated ☐ Divorced
Parent/Guardian 2	
Title	☐ Mr ☐ Dr
Surname	
Given Name/s	
Contact Phone Number	
Relationship to Child	
Marital Status	☐ Married ☐ Single ☐ DeFacto ☐ Separated ☐ Divorced
We ask that the parent or guardian of children at our practice complete the attached Authorisation to Communicate and access with other parties form. This form will become part of the child's file and it is your responsibility to inform us if authorisation for an individual is to be revoked or changed.	
Parenting Details (please complete this section if the child does not solely live with both parents)	
Is there currently any court orders in place around custody of this child?	☐ Yes ☐ No
If yes, please provide details	
Is there currently any non-court ordered agreements in place around custody of this child?	☐ Yes ☐ No
If Yes, please provide details	
To ensure that we provide the best protection to your child, we may ask you to provide evidence of court orders, agreements or parenting plans.	

Reminder System

Our practice provides our patients with preventative care and early case detection reminders such as immunisation, annual health checks, skin checks and pap smears.

Do you wish to have any relevant health reminders sent to you about your child?	
☐ Yes	☐ No
If we need to contact you, what is you preferred method of contact?	
☐ Home Phone ☐ Mobile Phone	☐ Mail ☐ Email

Your Child's Health History

Immunisations			
Is your child currently up to date with their childhood immunisations?	☐ Yes	☐ No	☐ Don't Know

Please list current or past operations, hospital admissions, (if none write NIL)	
Year	Details

Is your child currently under the care of a specialist?	
☐ Yes, please specify who	☐ No

Does your child regularly see an Allied Health Professional e.g. physiotherapist, Occupational Therapist, Speech Therapist)	
☐ Yes, please specify who	☐ No

Does your child have any allergies or sensitivities to any drugs or dressings?	
☐ Yes, please specify Type of Reaction:	☐ No, Nil Known

Current Medication

Please list **ALL** tablets, inhalers, patches, gels, creams, or injections your child currently takes or uses. Please include any 'natural' remedies such as herbal, homeopathic and vitamin supplements.	
Name of medication	**Dosage**

If you require more space; please list medication on the reverse side of this page.

Family History

Has anyone in your child's close family suffered from the following?

(please state the relationship of the relative to the child e.g. mother, father, sister, brother, maternal grandmother, paternal grandfather)

Have you suffered from any of the following – Currently or in the past?			
Disease	Relative	Disease	Relative
☐ Heart Attack		☐ Bowel Cancer	
☐ High Blood Pressure		☐ Ovarian Cancer	
☐ Stroke		☐ Cervical Cancer	
☐ Blood Clot(s)/DVT		☐ Uterine Cancer	
☐ High Cholesterol		☐ Prostate Cancer	
☐ Diabetes		☐ Skin Cancer	
☐ Thyroid Disease		☐ Any other cancer	
☐ Breast Cancer		☐ Depression	
☐ Schizophrenia		☐ Arthritis	
Other, please list			

Health Information Collection and Use Consent Form

PIVOTAL health

As a patient of our medical practice we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs.

We aim to protect the privacy and secure storage of your health information. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information.

We require your consent to collect personal information about you and to use the information you provide in the following ways. Please read this consent form carefully, and sign where indicated below.
Administrative purposes in running our medical practice.

- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to others involved in your healthcare including treating doctors and specialists outside this medical practice. This may occur through referral to other doctors, or for medical tests and in the reports or results returned to us following referrals.
- Disclosure to other doctors in the practice, locums etc. attached to the practice for the purpose of patient care and teaching.
- For research and quality assurance activities to improve individual and community health care and practice management. Usually information that does not identify you is used but should information that will identify you be required you will be informed and given the opportunity to "opt out" of any involvement.
- To comply with any legislative or regulatory requirements e.g. notifiable diseases.
- For reminder letters which may be sent to you regarding your health care and management.

You can decline to have your health information used in all or some of the ways outlined above but it may influence our ability to manage your health care to provide the best outcome for you.

*Please sign consent below.

I have read the information above and understand the reasons why personal information must be collected.	☐
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to my child.	☐
I am aware of my rights to access the information collected about my child, except in some circumstances where access may be legitimately withheld. I will be given an explanation in these circumstances.	☐
I understand that if my child's 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 child's information by the practice for the purpose set out above, subject to any limitations on access or disclosure of which I notify this practice.	☐
OR	
I am unsure and would like to discuss this further with someone from the medical practice before I sign.	☐

We thank you for taking the time to complete this questionnaire. Please return this to the reception staff on completion. Where possible we do ask that this completed form is returned to the practice at least 2 working days before your appointment.

I, _____ (printed name of guardian), the _____ (relationship to child) confirm that the above information is true and correct to my knowledge.

Signed: _____ Date:_____