**NORTH COBURG MEDICAL CENTRE PATIENT REGISTRATION FORM (CHILD)**

**HOW DID YOU HEAR ABOUT US** **🞎** INTERNET **🞎** FRIEND/FAMILY **🞎** HEALTH ENGINE **🞎** PHARMACY

**🞎**NEWSPAPER **🞎**OTHER………………………………………………….  
**Please ensure that you answer all questions ON BEHALF OF YOUR CHILD and hand back to reception once completed.**

**PART A: ALL patients are asked to complete the following. (PLEASE PRINT)**

|  |  |
| --- | --- |
| **TITLE:** | **🞎 MISS 🞎 MSTR 🞎 OTHER:** |
| **SURNAME:** |  |
| **FIRST NAME:** |  |
| PREFERRED NAME: | Date of Birth: \_\_\_\_\_\_ /\_\_\_\_\_\_ /\_\_\_\_\_\_ |
| **STREET ADDRESS:** |  |

|  |  |  |
| --- | --- | --- |
| **MEDICARE NUMBER:** | **Ref:** | **Expiry Date:** |
| **HCC NUMBER:** |  | **Expiry Date:** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **EMERGENCY CONTACT 1** |  | **EMERGENCY CONTACT 2** | | |
| **FULL NAME:** |  | **FULL NAME:** |  |  |
| **RELATIONSHIP TO PATIENT:** |  | **RELATIONSHIP TO PATIENT:** | |  |
| **ADDRESS:** |  | **ADDRESS:** | |  |
| **CONTACT NUMBERS:** | **HOME:**  **MOB:** | **CONTACT NUMBERS:** | | **HOME:**  **MOB:** |

**To assist with health initiatives - are you Aboriginal or Torres Strait Islander?**

**🞎** Yes - Aboriginal **🞎** Yes - Torres Strait Islander **🞎** Yes - Aboriginal & Torres Strait Islander **🞎** No

**Are all Childhood Immunisations up to date?**   
**🞎** Yes **🞎** No (Please elaborate on which  
 ones need catching up on)  
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**Do you have any allergies or are you sensitive to drugs or dressings?**

**🞎** Yes (please list and describe reaction below) **🞎** No

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| --- |
| **Any past medical history?**  **🞎** Yes, please elaborate **🞎** No  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Are you an Interstate or Overseas visitor to Melbourne? **🞎** Yes **🞎**No

**Do you intend to have ongoing medical care provided by North Coburg Medical Centre? 🞎 Yes 🞎 No \_\_**

**PATIENT PRIVACY:** To provide a high standard of medical care we need to collect personal information from our patients. Thisinformation is usually collected from the patient but also from family members and other health care providers. At times some of this information needs to be shared with doctors auditing our medical records as part of the RACGP accreditation process and other health care providers or we may be legally bound to disclose personal information. All persons accessing your health information are bound by confidentiality. Please do not hesitate to discuss any concerns, questions or complaints about any issues related to the privacy of your personal information with your Doctor.

***Practice Information Brochure*** *If you are a new patient please ask at reception for a copy of our Practice Information Brochure.*

***Personally Controlled eHealth Record*** *If you would more information or assistance in creating your* ***Personally Controlled eHealth Record*** *please make an appointment with the Practice Manager*.

**Signature:** ……………………………………........................…. **Date: \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_\_\_**