**Patient Information Form - CHILD**

*(To be completed for all individuals under the age of 14)*

**Child details:**

Title: First Name(s): Surname:

Date of Birth:

Street Address:

Suburb: Post Code:

Home Phone: Mobile: Email:

Medicare Card Number: Ref No: Expiry Date:

Pension Number: Expiry Date:

Health Care Card: Expiry Date:

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**Parent / Guardian details:**

Name: DOB: Relationship to Child:

Are you a patient of this Practice? **Yes**  **No**  If **No,** please provide the following details:

Is your address and further contact information the same as the child? **Yes**  **No** 

If **No**, please please provide the following details:

Street Address:

Suburb: Post Code:

Home Phone: Mobile:

Email:

Medicare Number: Ref: Exp:

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**Next of Kin**

Name: Contact Number:

**Emergency Contact** Same as Next of Kin 

Name of the person we can contact if needed: Relationship to You:

Contact number:

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**Further Information:**

**Are you of Aboriginal or Torres Strait Islander descent? Yes**  **No** 

 Aboriginal  Torres Strait Islander 

Do you have any cultural, religious or other background information you would like your doctor to be aware of? Yes  No 

Do you require a translator? Yes  No Language

What is your preferred method for this practice to contact you:

Yes - by Mail

Yes - by Email

Yes - by SMS

**Do you consent to SMS confirmation texts the day before your appointment? Yes  No **

**Our practice will need to collect your personal information to provide healthcare services to you. Our privacy policy for patients is available at reception. We are committed to providing our patients with the best care.**