

LAURIMAR MEDICAL

120 Painted Hills Road

Doreen, VIC 3754,

TEL: 9717 0804

FAX: 9717 0806

PATIENT REGISTRATION FORM (CHILDREN)

For your first appointment, please attend the practice 10 minutes before your appointment time. This allows your registration to be completed in time for you to see the Doctor.

Once completed, please hand this section of the questionnaire to the reception.

Title	Name	Surname
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Date of birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	MEDICARE NO:
		REF: EXPIRY:

Do you have a <input type="checkbox"/> Health Care Card	Card no.	Expiry date:
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ETHNICITY: Aboriginal Torres Strait Islander Aboriginal and Torres Strait Islander NON ATSI

HOME ADDRESS:	SCHOOL:
Postcode	Postcode

PARENT / CONTACT (1): <input type="checkbox"/> EMERGENCY CONTACT	PARENT / CONTACT (2): <input type="checkbox"/> EMERGENCY CONTACT
NAME:	NAME:
ADDRESS:	ADDRESS:
TELEPHONE:	TELEPHONE:
EMAIL:	EMAIL:

PAST MEDICAL HISTORY:

ARE ALL THE IMMUNISATIONS UP TO DATE? YES NO

MEDICATIONS:

ALLERGIES: _____

PATIENT PRIVACY Information: To provide a high standard of medical care we need to collect personal information from our patients. This information 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 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. We will be offering a service to contact you via sms regarding your recall appointments.

I give permission for **LAURIMAR MEDICAL** to contact me via SMS Yes No
 email Yes No

I give permission for Laurimar Medical to release my records to Mernda Village Medical & Dental and vice versa

Patient / Guardian Signature _____ Date _____