A/Prof J Preddy Dr N Snyman Dr T Pitts Dr M Suthern
Dr R Seth Dr L Finney Dr C Leung Dr L Trompf
Dr O Sainsbury Dr R Wilkinson

Child's Surname: .... **DOB:** ....**(M / F)**

Child's First Name: .... **Child's Middle Name:** ....

Address Residential: .... **Postal:** ....

....

....

Please tick if appropriate: Aboriginal ☐ **Torres Strait Islander** ☐ **Both Aboriginal & Torres Strait Islander** ☐

Who is your child's usual GP or GP clinic?: Name... Address:...

Child's Medicare Number: __ __ __ __ __ __ __ __ __ __ **Ref No*:** ____ **Expiry Date:** ____ /____

Child's Pension Number: .... **Expiry Date:** ....

Private Health Insurance: Yes / No - *if "Yes" please select: Hospital cover* ☐ ***or Extras only*** ☐

Name of Fund: .... **Membership Number:** .... **Ref No*:** ......

**Number next to childs' name*

<u>Parents/ Carer Details:</u> (please circle)

Name: ....**Relationship to child:**...............................**Occupation:** ....

Phone No: Home .... Work.. Mobile:...** ☐

Name: .... **Relationship to child:.**...........................**Occupation**:..

Phone No: Home.................................... Work... Mobile:...** ☐

**** Please tick which mobile you wish to receive your SMS appointment reminder on.**

Are the child's parents: Married / Defacto / Separated / Divorced / Widowed / Single *(<u>please circle</u>).*

If separated or divorced, who is the child's primary carer?...

Are there any court orders / custody arrangements for the child? Yes / No

If yes, please provide details or a copy of the court orders with your form ....

We will email a copy your child's CONSULTATION LETTER to you, rather than post unless you nominate otherwise. If you do not wish to have correspondence sent by email, please tick ☐

Email: ____

PLEASE TURN OVER……

ACCOUNT HOLDER DETAILS (person responsible for the account): parent/carer)

Title: .... **First Name:** .... **Surname:** ....

Date of Birth: ....

Account Payer Medicare Card Number : __ __ __ __ __ __ __ __ __ __ **Ref No:** ___ **Expiry Date:** ____ /____

OR

AGENCY DETAILS RESPONSIBLE FOR ACCOUNT: (eg. Dept of Community & Justice, Anglicare, Caresouth etc.)

Agency name: ……………………………………………………………… **Town**: ………………………………………………………………………………………

Caseworker: ………………………………………………**Phone**: ……………………………………**Email**………………………………………………………

If there are any other agencies involved, please supply details:

Agency name: ……………………………………………………………… **Town**: ………………………………………………………………………………………

Caseworker: ………………………………………………**Phone**: ……………………………………**Email**………………………………………………………

PRIVACY INFORMATION

We require your consent to collect personal information about you and your child. Please read this information carefully, and sign where indicated below.

This medical practice collects personal information from you and your child so we can provide your child with the best possible health care. We require you to provide us with personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your child's health care needs. The collection, use and storage of you and your child's personal information is outlined in our Privacy Policy, a copy of which is available on our website (www.riverinapaediatrics.com.au), or upon request. This policy outlines that we will use the information you and your child provide in the following ways:

- For administrative purposes in running our medical practice.
- For billing purposes, including compliance with Medicare.
- Where we may be permitted or required by law to disclose your personal information to third parties. For example to insurers, solicitors, government regulatory bodies, tribunals, courts of law, hospitals, debt collection agents, the electronic transfer of prescription service or to the Myhealth record system.
- We may also from time to time provide statistical data to third parties for research purposes.
- Disclosure to others involved in your child's health care, 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 the referrals.

I have read the information above and understand the reasons why my information must be collected.

I am aware of my right to access the information collected about myself or my child except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my 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 information by this practice for the purposes set out above, subject to any limitations on access or disclosure of which I notify this practice.

Signed:……….. Relationship to Child ……….. Date …………………….