WEST GIPPSLAND
PAEDIATRIC
GROUP

Dr. Michael Nowotny
Dr. Chris Smith
Dr. Sari Hayllar
Dr. James Carter
Dr. Brendan Lacey
Dr. Christian Catalano

Patient's Surname:_____
AS IT APPEARS ON MEDICARE CARD. PLEASE ADVISE ANY ALTERNATIVE SURNAME.

Patient's Given Names:_____ □ Male □ Female

Residential Address:_____

_____ Postcode: _____

Postal Address:_____ Postcode: _____

Date of birth: ____/_____/____

Home Phone:_____ **Mobile Phone:**_____

I give consent to receive a SMS to confirm appointments:

□ **Yes** □ **No** **Signature:**_____

Parent / Guardian's details and contact information

Name; _____Address; _____

Relationship to child;_____

Home phone:_____ Mobile phone: _____

Parent 1 details

Name _____

D.O.B: _____
FOR MEDICARE PURPOSES

Occupation _____

Business phone:_____

Parent 2 details

Name_____

D.O.B:_____
FOR MEDICARE PURPOSES

Occupation _____

Business phone: _____

Who is responsible for the account?
Mr / Mrs / Miss / Ms _____ _____
First Name *Surname*

Relationship to patient:_____

I accept full responsibility for payment of accounts: - _____
Signature

Medicare No. _____ **Ref No**_____**Expiry Date**____/_____
(NUMBER NEXT TO PATIENTS NAME)

Parents Medicare Ref Number – Mum: _____ **Dad:** _____

Pension No_____ **Expiry Date**____/____/_____

Health Care Card No_____ **Expiry Date**____/____/_____

Name of usual GP:_____

Referring Doctor:_____

Alternative Contact:

Name: _____

Address: _____

Telephone: _____

Relationship to patient: _____

Are there any custody restrictions applicable to this child? □ ***YES*** □ ***NO***
If yes, please discuss this with the Paediatrician.

OTHER CHILDREN (brothers, sisters or other children who live in the household)

Name	Date of Birth	Name	Date of Birth
.....	...../...../.....	.....	...../...../.....
.....	...../...../.....	.....	...../...../.....
.....	...../...../.....	.....	...../...../.....

MEDICATIONS – Please list – (*including pills, syrups, lotions or herbal remedies*)

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Does your child suffer from any allergies or bad reactions to drugs or treatments, etc? If yes please give details .....

.....

MOTHER'S PREGNANCY:

Were you well during pregnancy? (*flu colds, operations, accidents*).....

Did you smoke during your pregnancy? □ YES □ NO. Drink alcohol? □ YES □ NO

Did you take any medicine during the pregnancy?.....

Was there any bleeding or fluid loss before the delivery? If so, when?.....

Did you have any ultrasounds or Xrays? If so, when and result(s)?

Ultrasound..... Xray.....

Have there been any miscarriage/still births? .....

BIRTH:

How long was the labour?..... Did labour start naturally? .....

Was baby born early, late or on time? (*eg 3 weeks early*).....

Was any help necessary with forceps, vacuum or was a Caesarean performed?.....

What was the baby's birth weight?.....

Did baby's condition at the birth cause any concern?.....

Did he/she cry normally?.....

Did he/she stay in special care nursery for any reason?.....

Is there any family history of fits, slow development, any serious family illness or anyone in the family with problems like your child? .....

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DEVELOPMENT – (for children currently under 6 years of age)

How old was your child when he/she:

Smiled.....Sat unsupported.....Said first word.....

Crawled.....Walked unaided.....Fed him/herself.....

Has your child lost the ability to do any tasks that he/she could formally do? □ YES □ NO

IMMUNISATION

Is your child fully immunised? □ YES □ NO

Details.....

OTHER MEDICAL ILLNESSES, OR HOSPITAL ADMISSIONS, OR OPERATIONS:

Details.....

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