Bayside Specialist Clinic

Shop 1/17 Waterloo Street, Cleveland. QLD 4163

Ph: 3843 1415 Fax: 3483 1422

Patient Personal Details

Patient's Name___________________________Age__________________Gender_________DOB:_________

Residential Address____

____

FOR BILLING PURPOSES MEDICARE REQUIRES THE FOLLOWING IMPORTANT INFORMATION

Mother's Name____ DOB_______________________

Occupation ______________________________ Mothers Mobile Number:____________________________

Father's Name____DOB_______________________

Occupation ______________________________Fathers Mobile Number:______________________________

Telephone Numbers: Home______________________________________

Alternative Contact Telephone Name & Number:____

Email Address____

Person Responsible for Accounts (Parent's Name)____

Name and Address of General Practitioner____

____

HEALTHCARE COVER:

Medicare No: __ __ __ __ __ __ __ __ __ __ Child's Ref No: ____ Expiry: _______ /________

Yes / No Do you have current Private Health Insurance Cover? Is your cover OSHC?

Health Fund: _______________________________________ Membership No: ________________________ Yes / No Have you held your **Hospital** cover with your Private Health Fund for more than 12 months?

**** **If you are anticipating hospitalisation and / or surgery. Please check full details of your health cover with your Private Health Insurance Company** ****

PATIENT/FAMILY HISTORY:

Please place a tick if you or your family have ever had problems with any of the following:

	Patient/Family		Patient/Family		Patient/Family
Anaemia	____ ____	ADHD/ADD	____ ____	Autism	____ ____
Bleeding problems	____ ____	Birth Defects	____ ____	Cancer	____ ____
Cerebral Palsy	____ ____	Diabetes	____ ____	Down Syndrome	____ ____
Genetic Disease	____ _____	Headaches	____ ____	Heart problems	____ ____
Hearing loss	____ ____	High blood pressure	____ ____	High cholesterol	____ ____
Infertility	____ ____	Kidney problems	____ ____	Liver function	____ ____
Lung problems	____ ____	Psychiatric	____ ____	Seizures	____ ____
Substance abuse	____ ____	Thyroid	____ ____	Tuberculosis	____ ____
Urinary tract	____ ____	Other	____ ____		

BIRTH & DEVELOPMENT Full
Term? **Yes** or **No**
Birth weight_______________
Delivery: Vaginal [ ] C-Section [ ]
Birth complications____
____

Pregnancy issues (med/alcohol/smoking/other)____

CURRENT MEDICATIONS: Please list all Medications & Dosage you are currently taking.

____

____

IMMUNISATION HISTORY:

____

____

ALLERGIES: Please list all Medications from which you have had an allergic reaction.

____

____

PAST MEDICAL HISTORY

Infections____

Behaviour Problems____

Surgeries____

Hospitalisations____

Other____

FAMILY & SOCIAL HISTORY:

Smoking exposure at home? **Yes** or **No**

Day Care? **Yes** or **No**

Siblings (how many)? __________

Pets (what kind)? ______________________________

Please list all people who currently live in the home ____

____

Have you seen or consulted specialists, or other health care providers? **Yes** or **No**

If yes, please list____

____

EDUCATION HISTORY:

School Name___________________________________

Teacher's Name_________________________________

Year/Grade______________________________________

Consent & Release Of Medical Information

I give consent to Bayside Paediatrics to contact any of my previous medical practitioners or hospitals to obtain previous health records that are relevant to my current care.

I authorise those previous practitioners and hospitals to release such information, even sensitive health records, to Bayside Paediatrics as requested.

How did you hear about us? □ GP referral □ Website/Google □ Cinema Advert □ Facebook □ Referred by a friend

I understand that during my consultation it may be necessary for minor procedures to be performed and I consent to those procedures being carried out after suitable consultation with myself.

Parent/Guardian/Carer's Signature____ Date ____/____/________