 PATIENT DETAILS – CHILD

First Name: ................................ Middle Name: ……………… Last Name: ..................................

Known As: …………….….. Date Of Birth: …….../…....../.............. Gender: *M / F / Unspecified*

Address: ........................................................................................................... Postcode: ………..

*\*Please list Parent 1 as the primary point of contact for us to communicate with. We will use this mobile number as the preferred contact.*

Parent 1’s full name: Dr/Mrs/Ms/Miss/Mr ................................................... Mobile: ...........................

Parent 2’s full name: Dr/Mrs/Ms/Miss/Mr ................................................... Mobile: ...........................

Home/Work Ph Number: ............................. Email: .......................................................................

*May we add you to our email list for SOS practice information, surveys and correspondence? Yes / No*

***Please don’t worry – we won’t hound you or share your email address***

*May we use SMS / email to communicate with you regarding your appointment? Yes / No*

Do any other family members attend this practice? *Yes / No* Name/s: …………………………….

**Medicare:**

Number: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ CHILD’S reference number: ……. Expiry: ........

*If you would like us to submit the Medicare claim for you, please provide:*

Name of PARENT on Medicare card: .......................................................

Reference number: ……….. Same parent’s date of birth: ....................................

**Private Health Fund:**

Name of Fund:­­­­­­­­­­­­­ ............................................ Number: ……………......................... Reference: …..

**Pension Card:**

Number: ..............................................Type: *Aged / Blind / Disability*  Exp: .........

**Referring Doctor/Optometrist:**

Name: …………….…………………………………………………….. Phone: ….……..………..…….

Address: …………………………………………………………………………………………………….

**Your regular Doctor/GP**:

Name: …………….…………………………………………………….. Phone: ….……..………..…….

Address: …………………………………………………………………………………………………….

Any other doctors involved in your care: Name: ……………………………….... Phone: …………

Address: ………………………………………………………………………………………………..

*Do you consent to reports being sent to all medical providers listed above?* *Yes / No*

**How did you hear about us:** *Google / Web search / Referring doctor or optometrist / Word of Mouth / Other (please specify)* ………………………………………………………………………

** PRIVACY STATEMENT - Child** *(parents/guardians to sign)*

**Collection of Personal Information, Privacy Act 1988 (Cth) and HRIP Act 2002 (NSW)**

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assist, diagnose and treat illnesses and be pro-active in your health care. We will also use the information you provide in the following ways:

• Administrative purposes in running our medical practice

• Billing purposes, including compliance with Medicare and Health Insurance Commission requirements

• Disclosure to others involved in your health care, including treating doctors and specialists outside this medical practice

• Disclosure to other doctors in the practice, locums and by Registrars attached to the practice for the purpose of teaching. Please let us know if you do not want your records accessed for this purpose, and we will note your record accordingly

• Disclosure for research and quality assurance activities to improve individual and community health care and practice management. You will be informed when such activities are being conducted and given the opportunity to opt-out of any involvement

• To undertake recalls, reminders and surveys as part of our quality improvement activities

• To send you updates on our practice and relevant information by way of our newsletter

• Clinical photos or videos of you or your child may be taken to record clinical findings. You will be asked for permission before this is undertaken. The primary purpose of these photos is for the patients medical record. The secondary purposes of these photos are for education of health professionals and students at SOS and other hospitals/colleges/universities/conferences, and for publication in medical/scientific journals/textbooks. In the case of written publication in a journal or textbook, you would be contacted to obtain specific written permission. No information that personally identifies you would be disclosed

• In the rare event of an overdue account, your information may be sent to a debt collection agency or solicitor. Any fees incurred by us from the debt collection agency or the solicitor will be passed on to you in full

I have read the information above and understand the reasons why my information must be collected. I understand that I am not obliged to provide any information requested of me, but that my failure to do so might compromise the quality of the health care and treatment given to me.

I am also aware that this practice has a privacy policy which contains information about accessing and seeking correction of personal information, privacy complaints handling process, and whether the practice is likely to disclose personal information to overseas recipients. A full copy of our privacy policy is available on request.

I am aware of my right to access the information collected about me, except in circumstances where access might be legitimately withheld. I understand I will be given an explanation in these circumstances. I understand that if I request access to information about me, it must be done so in writing, and the practice will be entitled to charge fees to cover time and administrative costs which may not be covered by a Medicare rebate.

I understand that if my information is to be used for any 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 that I notify this practice of.

These records are stored securely and may be kept for up to seven (7) years following your last consultation. If necessary, for the continuity of your medical care, this information may be shared with other health practitioners involved in your treatment. In certain circumstances there may be a legal obligation to disclose clinical information.

***Please note that SOS is a private billing practice. Payment is required on the day of the consultation. Payment of all surgical accounts is due within 7 days of the surgery date. Late payments of accounts may incur additional costs.***

**By signing this form you are agreeing to the above. Please cross out any parts that you do not agree to. Please let our reception staff know if you have not consented to this form in its entirety.**

Parent/Guardian Signature: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name: Patient’s Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_