

Bayside Paediatrics

Suite 15, Level 1, Mater Health Centre, 16 Weippin St, Cleveland, QLD 4163.

Ph: 3163 7424 Fax: 3163 7425

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.

Website page is: www.baysideog.com.au and Facebook page is: [facebook.com/BaysideOG](https://www.facebook.com/BaysideOG)

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 ____/____/____