Child's Personal Details

Given name:				
Surname:		Male:		Female:	
Date of birth:				
Address:				
Suburb/Town:		Postcode:		
Telephone:	(w)	(h)	(m)	
Any known allergies?				

Carer 1's name:		DOB:	
Carer 2's name:		DOB:	
Person responsible for the account:			
Sibling name(s) and age(s):			

Do you wish to receive correspondence via email?	YES / NO	If Yes, email address:
Do you wish to receive messages/results via text?	YES / NO	

Pension card (Blue)	YES / NO	Card Number:

Private health insurance	YES / NO	Fund name:
Fund number:		

Medicare number:		Child's reference no: (Found to the left of the child's name)	

Referring doctor:	
Usual doctor:	

It is my responsibility to phone the Paediatrics Ballarat to obtain the results of tests that may have been ordered by my doctor.

I authorise Paediatrics Ballarat to submit my unpaid account to Medicare, so that Medicare can assess my claim and issue me a cheque, made payable to the practitioner for the Medicare benefit.

I have read the above statements and consent to their conditions.

Signature Parent/Guardian...................................

PLEASE READ & SIGN THE PRIVACY CONSENT ON THE FOLLOWING PAGE

PLEASE TURN OVER

PRIVACY CONSENT FORM

I, ________________________________ have read and understand the information.

Contained in the **Paediatrics Ballarat** *Practice Privacy Policy*, is the following:

- the types of personal information collected by the Practice, the reasons why it is necessary to collect it and the circumstances in which my personal information may be used or disclosed;
- that I may request access to my personal information, which may be granted in accordance with the practice's *Access to Personal Information Policy*. I will be provided with a written reason if access is denied;
- that I may request an amendment to my personal information if it is incorrect. I will be provided with a written reason if a request for amendment is denied;
- that my personal information will not be used for direct marketing or disclosed to overseas recipients;
- that I am not obliged to provide the Practice with my personal information, but withholding information may limit the Practice's ability to provide me with full service.
- that I have the right to lodge a complaint about the handling of my personal information if I am dissatisfied, which will be dealt with in accordance with the Practice's complaint handling procedure.

REQUEST TO ACCESS MEDICAL RECORDS FORM

I, parent/guardian of

guardian name *child's name*

give consent for ***Paediatrics Ballarat*** to access the documents for my child.

I understand the Practice may request I attend a consultation with my doctor to discuss the information contained in my medical record. In this instance, a consultation fee will apply which is not redeemable via Medicare.

I understand I will not be permitted to remove, amend or delete any contents from my medical record. If I wish to make any amendments or deletions, I must submit a request in writing to the Practice using the *Request to Amend Medical Record Form*.

I understand I am permitted to obtain copies of some or all of the contents of my medical record. Copies may not be available immediately at the time of inspection but will be made available to me as soon as practicable after the inspection.

Signed ________________________________
Patient or parent/guardian of patient

Date ________________________________