MediConnect Consulting

Suite 8/259 McCullough St Sunnybank Q

Dr Haseena Mohamed

Child Patient Information & Medical History Form

Patient's Full Name: _____

Gender: ☐ Male ☐ Female Date of Birth: _____

Home Address: _____

Telephone: Home: _____ Mobile: _____

Email: _____

Patient's School/Occupation: _____

Patient's referring Doctor: _____

Regular GP**:** _____

MEDICARE NUMBER:

_____

Reference Number: ☐ (number to the left of your name) Expiry date: _____

Private Health Insurance

Name of Fund: _____ Membership Number _____

Parent Details

Father's Name: _____ DOB: _____

Address (as above/other): _____

Telephone: Home: _____ Mobile: _____

Do you want **correspondence** ☐ Yes ☐ No

MEDICARE NUMBER:

_____

Reference Number: ☐ (number to the left of your name) Expiry date: _____

Private Health Insurance

Name of Fund: _____ Membership Number: _____

Mother's Name: _____ DOB: _____

Address (as above/other): _____

Telephone: Home: _____ Mobile: _____

Do you want **correspondence** ☐ Yes ☐ No

MEDICARE NUMBER:

_____

Reference Number: ☐ (number to the left of your name) Expiry date: _____

Private Health Insurance

Name of Fund: _____ Membership Number: _____

Party Responsible for accounts: ☐ Father ☐ Mother ☐ Other:

Contact details **if not parent**:

Name (include title): _____

Address: _____

Telephone: Home: _____ Mobile: _____

Please kindly note that, preparation and completion of medical reports (for eg. NDIS yearly review letter), claiming forms will incur separate non-Medicare rebatable charges of $100-$200.

Scripts outside of scheduled appointment times are $30

Telephone consultations are $120, if you have a valid referral you may receive a rebate of $39.20

Patient's Medicare History (Please tick where applicable)

☐ Asthma	☐ Birth defects	☐ Bleeding disorders	☐ Bone disorders
☐ Diabetes	☐ Emotional problems	☐ Epilepsy	☐ Growth problems
☐ Heart murmur	☐ Heart disease	☐ Hepatitis	
☐ High Blood Pressure	☐ Headaches/Migraines	☐ HIV/AIDS	☐ Kidney Disease

Allergies: _____

Other: _____

Current Medications: _____

Should you have any medical condition, which may require further precaution, please advise.

_____

Please note that a behavioural diagnosis cannot be made at the consultation without supporting letters provided by Allied Health Professionals.

To the best of my knowledge, the above information is complete and correct.

Parent Signature: _____ Name: _____ Date: _____

Privacy Policy

In accordance with the Federal Privacy Act 1988, we consider the protection of your privacy and personal information to be a high priority. Therefore, we realise that it is important that you are aware of why we collect, how we use and to whom we may disclose your information.

The policy of our practice is to follow these procedures:

- The information collected will be used for the purposes of providing treatment to you. Personal information such as your name, address and other details will be used for the purpose of accounts and payment, and writing to you about your treatment and our services.
- We may disclose your health information to other health care professionals or require it from them if necessary for your treatment. In that event, disclosure of your personal details will be minimised.
- We may also use parts of your health information for research purposes in study groups or at seminars and lectures as this may provide benefit to other patients. Your personal identity will not be disclosed.
- If any of the information we have about you is inaccurate, you may ask us to alter our records accordingly.

We respect your privacy and this information will be held in the strictest confidence.

Please sign here as confirmation that you understand and consent to our privacy policy:

Parent Signature: _____ Name: _____ Date: _____

Authority to Request/Refer Records to Healthcare Providers:

We may need to request records from your previous Paediatrician or Specialist to assist with your treatment planning. We also correspond and forward x-rays when required, with your General Practitioner or other specialists for treatment planning. During your treatment, we may need to refer you to other specialists. To ensure compliance with Federal and State Privacy Legislation we require your signed consent to work with other healthcare professionals.

Parent Signature: _____ Name: _____ Date: _____