

CHILD CONFIDENTIAL CLIENT INFORMATION FORM

THE CENTENNIAL PRACTICE

DATE:

PLEASE PRINT

Child's name

Child's date of birth _____ Place of birth _____

Medicare No. _____

Parents' names _____ Marital status _____

Mother's occupation _____

Father's occupation _____

Address _____

Postcode _____

Telephone HOME () _____ WORK () _____

MOBILE _____

E-mail _____

Other children

Name	Age at last birthday	Gender

GP _____ GP phone _____

GP address _____

How did you hear about this practice? _____

Emergency contact: Name _____ Relationship to client _____

Address _____

Telephone HOME () _____ WORK () _____

MOBILE _____

Privacy statement: We acknowledge our obligations to you under the Privacy Amendment (Private Sector) Act 2000. The personal information we collect about you will be used primarily to provide your health care. Your information may also be used for purposes including quality improvement, clinical training and as required by law.

Parental permission to provide initial assessment information to another professional? Yes No

Parent's signature _____ Date _____