**Southern Paediatrics & Allergy**

**Dr Ana Dosen, Dr Greg Blecher, Dr Jamie Cheah, Dr Chris Elliot, Dr Bernadette Hanna, Dr Sara Kashef, Dr Lynette Khoury, Dr Darren Shepherd, Dr Anthony Whelan, Briget Gurton, Hanan Saleh**

**CONFIDENTIAL PATIENT ACQUAINTANCE FORM**

***As part of our commitment in providing quality health care, it is necessary for us to maintain files pertaining to your child’s health. Your medical file is handled with the upmost respect for your privacy.***

***PLEASE COMPLETE IN BLOCK LETTERS***

**CHILD FAMILY NAME .......................................................................................................**

**CHILD GIVEN NAMES ......................................................................................... M / F**

**ADDRESS ............................................................................................................................**

**SUBURB ....................................................................................... POSTCODE ..................**

**DATE OF BIRTH ......../......../........ AGE ....................**

**PHONE (home) ...................................... (mobile) ..................................................**

**EMAIL ADDRESS:………………………………………………………………………………**

**MEDICARE NO: ...................................................... position # ....... .**

**PARENTS/CARERS NAMES ..................................................................................................**

**BANK ACCOUNT REGISTERED WITH MEDICARE: YES/NO (please circle)**

**PARENT DOB: (required for Medicare Identification)............................................................**

**PARENT MEDICARE POSITION #............................................**

**REFERRING DOCTOR ..............................................................**

**FAMILY DOCTOR .................................................................... Phone .............................**

**ADDRESS ............................................................................................................................**

***Please note that this is a private practice and fees are payable at the time of consultation. The fees charged by this practice are generally those recommended by the Australian Medical Association. These will be more than the Medicare rebate. Should payment of fees present a problem, please discuss this with the doctor or secretary. Accounts can be settled by cash, EFTPOS, cheque, Mastercard or Visa.***

***SIGNATURE .................................................................... DATE ..........................***