

Australian Paediatrics

Suite 61F, Level 1 Royal Randwick Shopping Centre

73 Belmore Road Randwick NSW 2031

Phone: (02) 9326 4500 Fax: (02) 9326 4822



All the doctors here at Australian Paediatrics are dedicated to providing our patients, their families, and the community with safe and efficient clinical care. To this end we ask that:

- The attached **Patient Acquaintance Form** is completed
- Any other attached **Forms** are completed

These documents, along with the **Referral Letter and ALL reports and results** that you may have regarding your child's medical issues, are scanned, and emailed to us as a **PDF file**, in advance, to upload onto our system.

Email: secretaryAP@outlook.com

An automatic SMS will be sent to your phone a week in advance to confirm the appointment. A follow-up courtesy phone call, a few days prior to the appointment, will also occur. Should you need to cancel/re-schedule, please call the rooms as soon as possible to allow us time to re-book the appointment.

With thanks,

Australian Paediatrics Team

Patient Acquaintance Form



Family Name: _____

First Name: _____ Other Names: _____

Address: _____

Postcode: _____

Date of Birth: _____ Gender (Circle): Male or Female

Mother's Name: _____ Father's Name: _____

Mother's DOB: _____ Father's DOB: _____

Phone (Home): _____ Phone (Home): _____

Phone (Work): _____ Phone (Work): _____

Phone (Mob): _____ Phone (Mob): _____

Email: _____ Email: _____

Allergies: _____

Private Health Fund Name: _____

Private Health Fund Number: _____

Medicare Number:

Expires: / Position on Medicare card:

Referring Doctor's Name: _____

Referring Doctor's Address: _____

Postcode: _____

GP's Name: _____

GP's Address: _____

Postcode: _____

I authorise the staff of Australian Paediatrics to communicate with my GP, other health professionals/institutions, educational facilities, and clinical therapists in regards to information relevant to my child's clinical care, with the exception of:

Signed: _____ Date: _____