Welcome to the practice of Dr Michael Bellemore.

Please complete this form to assist us in providing your child with the best treatment. For your information the Privacy Policy of our practice is printed on the back of this form.

Child's Surname:_____

Child's First Name:_____

Date of Birth:_____ Male / Female

Address:_____

_____ Post Code:_____

Mother's Full Name:_____D.O.B.:

Address (*if different to child's*):_____

Father's Full Name:_____D.O.B.:

Address (*if different to child's*):_____

Phone – Home:_____ Work:_____

Mobile:_____

Email address: _____

Name of **Referring** Doctor:_____

Name & Address of **Family** Doctor (***If different to referrer***):_____

_____

_____

Medicare number: _ _ _ _ _ _ _ _ _ _ _ Reference number: _ Valid to _ _ /_ _ _ _

Parent Medicare: _ _ _ _ _ _ _ _ _ _ _ Reference number: _ Valid to _ _ /_ _ _ _

Do you have private health insurance: YES / NO

Health Fund Name:_____

OUR FEES:

Consultation fees are above the schedule fee. Payment of fees is required on the day of consultation. There may be an additional charge for procedures undertaken (eg. ultrasound, plaster). An initial consultation is **$300.00** and subsequent consultations are **$150.00**.

I have read the above and agree to abide by the payment terms of this practice. I consent to all or any of the above information to be released to other health providers and agencies during the course of my child's treatment.

Signature:_____ Date:_____ Thank-you.