

**Dr David Roberts - Child Registration Form**

Child's Surname: .....

School Attending:.....

Child's Given Name: .....

Referring Doctor:

Date of Birth: .....

Name:.....

Address: .....

Address:.....

..... Postcode: .....

.....

Telephone: Home:.....

.....

Work: .....

Family Doctor (if different to above):

Mobile: .....

Name:.....

Should you **not** wish to receive SMS **appointment reminders** please tick

Address:.....

Mother's Name: .....

.....

Father's Name: .....

Dr Roberts sees patients upon referral and by appointment only. If you must change your appointment please contact us ASAP. We ask for at least 2 working days' notice. We no longer charge a Late Cancellation or Non-attendance Fee. In these circumstances, please pay us the courtesy of calling to inform us, otherwise Dr Roberts may withdraw from care.

Medicare Number.....EXP.....

Child Reference Number .....

Parent Reference Number .....

Person & Address Responsible for Account:  
(ie: Mother/father/Department Child Protection)

.....

Signature: .....

Date: .....