

This is not a bulk billing practice
However concessions may apply at some of our branches please check with reception
Consultations are by appointment only and payment on the day is required

PATIENT HEALTH SUMMARY

TITLE _____ SURNAME: _____ GIVEN NAMES _____

D/O/B ____/____/____ Marital Status: Single/Married/Other _____

HOME ADDRESS _____

_____ Post Code _____ Country of Birth. _____

Postal Address if different from above _____

Occupation _____

Employer _____

Home Phone _____

Work Phone _____

Mobile _____

Email: _____

Medicare Card No _____ Expiry Date _____ Patient Ref No. on card _____

Are you of **Aboriginal and/or Torres Strait Islander** origin?

Yes Aboriginal

Yes Torres Strait Islander

Veterans Affairs Gold Card/ White Card DVA File No _____

E- Health Registered: Yes / No (please circle)

Patient Pension Card CRN _____ Expiry Date _____

Health Care Card CRN _____ Expiry Date _____

Private Health Fund: Yes/No Basic/Intermediate/Top (please circle)

Do you know of any Allergies? Yes / No Please state: _____ Reaction _____

NEXT OF KIN: Name _____ DOB _____

Relationship to patient _____ Medicare Ref No (if payer) _____

Address _____

Phone No _____

SECOND Contact (different from NOK) _____ Phone No _____

Relationship to patient _____

This practice uses a Patient Recall System. Please indicate if you wish to participate: Yes/No

Eg - Reminders are sent for appointments, smears, immunizations and other routine health checks

This can be by SMS, Letter and/or Telephone Call

Please read our Privacy Statement

Please note we do not store Radiology Film. If you require your x-rays please make sure you take them with you at the end of your consultation

This practice has an **Information Brochure** which we encourage all our patients to read so they are aware of the services we offer. Ask at **Reception** for a copy

How did you hear about CQ Medicentre (please circle)

Friend, Family Member, Local Paper, Yellow/White Pages, Google, Other

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