CQ Medicentre
Better Healthcare Today

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 _____
Preferred Name _____
Middle Name _____
GIVEN NAMES _____
D/O/B ____/____/____
Birth Sex: _____
Gender Identify: _____
Pronouns: _____

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

☐ **Aboriginal**
☐ **Torres Strait Islander**
☐ **Aboriginal and Torres Strait Islander**
☐ **N/A**

Address _____
City _____ **Postcode**_____
Postal Address_____
City _____ **Postcode**_____
Home Phone: _____

Work Phone: _____

Mobile: _____
Email: _____
Contact Via ☐ Home ☐ Work ☐ Mobile

Medicare Card No_____
Expiry Date ____/____/____
Patient Ref No. on card_____
Pension Card _____
Expiry Date ____/____/____
Health Care Card _____
Veterans Affairs ☐ Gold Card ☐ White Card
DVA File _____

Health Insurance
Health Insurance Fund _____
Health Insurance Number _____

Country of Birth _____

Next Of kin _____
Relationship _____
Next of kin No _____

Emergency Contact _____

Emergency Contact No _____
Relationship _____
Your Occupation _____
E- Health Registered: ☐ Yes ☐ No

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

Smoking History: ☐ Non-smoker ☐ Ex-smoker ☐ Current smoker **Year Started:** _____ **Year Ceased**:_____

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

City Centre Plaza, Rockhampton Q 4700
PO Box 6562, Redhill, Rockhampton Q 4700

Tel: 0749 214175
Fax: 0749 278271

CQ Medicentre
Better Healthcare Today

CONSENT TO COLLECTION OF PERSONAL AND HEALTHCARE INFORMATION

As a patient of this medical practice, we require you to provide us with your personal details and a full medical history, so that we may properly assess, diagnose, treat and be proactive in your health care needs. We aim to protect the privacy of your health information at all times. You can request a copy of our privacy policy, which includes information about the collection, use and disclosure of your health information and making a complaint about a breach of your privacy.

We require your consent to allow us to collect and use your personal information for the following reasons:

- Administrative purposes
- Billing purposes (including compliance with Medicare and the Department of Health and Ageing requirements)
- Disclosure to others involved in your healthcare. This may include allied health professionals, other specialists and health practitioners outside of this practice. This may occur through referral to others or for medical tests and in the reports or results returned to us following referral.
- For research and quality improvement purposes to improve individual and community health care and practice management (this will only be information that does not identify individual patients)
- To comply with regulatory or legislative requirements such as notifiable diseases or where the health and well-being of you or other/s is at significant risk of harm.
- For reminders and recalls which may be sent to you SMS, Email or letter regarding your healthcare and management.

You can decline to have your health information used in all or some of the ways outlined above, but it may influence the practice's ability to manage your healthcare to provide the best outcome.

PLEASE READ EACH STATEMENT CAREFULLY AND TICK THE BOX IF YOU AGREE	
I have read the information above and understand the reasons why the information must be collected	
I understand that I am not obliged to provide any information requested of me, but failure to do so may compromise the quality of health care and treatment given to me or if I provide information but want to put limitations on access or disclosure, I will discuss these with the practice beforehand.	
I am aware of my rights to access information collected about me, except in circumstances where access may be legitimately withheld. I understand I will receive an explanation in these circumstances.	
I understand that if my information is to be used for any other purposes other than those set out above, my further consent will be obtained.	
I consent to the handling of my information by the practice for the purposes set out on this form.	
I understand that depending on the age of my child, and given my child's right to privacy, in the clinical judgment of the doctor treating my child I may be prevented from access to information regarding my child's healthcare.	
I understand that if I request access to information held about me, I may be charged a fee to cover the administrative costs in providing access.	
This practice uses a Patient Recall System. Please indicate if you wish to participate: 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	
I consent to be sent reminders, results and reports by SMS: my mobile number is: _____	
OR **I consent to be sent reminders, results and reports by email: my email address:** **_____**	
OR I am unsure and would like to discuss further with someone from the medical practice before signing	

Patient Name: _____ **Date**:_____

Patient / Parent / Guardian signature: _____

City Centre Plaza, Rockhampton Q 4700
PO Box 6562, Redhill, Rockhampton Q 4700
Tel: 0749 214175
Fax: 0749 278271