313-315 Ross River Road, Aitkenvale Qld 4814
PO Box 131, Aitkenvale Qld 4814
Phone: 07 4725 0131 – Fax: 07 4779 1427
Email: fnq.admin@stocklandfamilypractice.com.au

Patient Information

DO YOU HAVE A COUGH, COLD, FEVER OR SORE THROAT? Please advise reception immediately!

Title: **Surname:** **Given Name/s:**

Preferred Name: **Gender:** M / F

Date of Birth: / / **Cultural Background:** ☐ Aboriginal ☐ Torres Strait Islander ☐ Non Indigenous

Country of Birth: **Ethnicity**:

Residential Address				**Postal Address** (If Different)			
Address:				Address:			
Suburb:		Post Code:		Suburb:		Post Code:	

Home: ( ) **Work:** **Mobile:**

Email:

Please advise reception if you don't consent to SMS reminders

Medicare No. **Reference:** **Expiry:**

Concession Card No: **Type:** Pension/ Health Care Card **Expiry:**

DVA Card: ☐ **White** ☐ **Gold** **Conditions:**

Health Insurance Fund: (if applicable) ☐ Yes ☐ No

Member No: _____

Next Of Kin		**Emergency Contact** (different contact)	
Name:		Name:	
Contact No:		Contact No:	
Relationship:		Relationship:	

Do you have any Allergies?:

☐ YES ☐ NO

Turn Page Over →

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CONSENT

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

We need this information to provide the best quality care. This form complies with RACPG *Standards for general practices.* This means that your personal Health information is kept private and secure, as required by Federal and State privacy laws. If you have any concerns, please leave blank and discuss with the Doctor.

Please notify us promptly of any changes in your contact details.
Accurate contact details help us identify you and your medical records, and allow us to contact you promptly about tests and results.

This medical practice collects information from you for the purpose of providing equality in health care. In the course of the consultation, your doctor may ask your personal details and a full medical history so we may properly access, diagnose, treat and be proactive in your health care needs. This means we may use the information you provide in the following ways:

- Administrative purposes in running our medical practice
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements
- Disclosure to others involved in your healthcare, including treating Doctors and Specialists outside the medical practice. This may occur through referral to other Doctors, for pathology and x-ray, in the reports, or results returned to us following the referrals
- Disclosure to other Doctors in the practice, Locums, Registrars, or Medical students attached to the practice for the purpose of patient care and teaching. Please let us know if you do not want your records assessed for these purposes, and we will note this on your record accordingly.
- Disclosure to a medical legal defence organisation if a medico-legal issue arises
- Pap Smear registry
- Australian Childhood Immunisation Register
- Family cancer register

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand and consent to FNQ Family Practice uploading a shared health summary to My Health Records. If I do not consent, I will inform reception upon arrival before seeing any health practitioner.

I understand and consent to FNQ Family Practice, Practice Policies and Procedures.

I understand that I am not obliged to provide information requested of me, but my failure to do so may compromise the quality of health care and treatment given to me.

I am aware of my right to access information collected about me, except in some circumstances where access might be legitimately withheld. I understand that I will be given an explanation in those circumstances.

I understand that if my information is to be used for any other purposes other than those set out above, subject to any limitations, access, or disclosure, that I notify the practice.

I understand that if I fail to attend any booked appointment without contacting the practice, I may be charged a cancellation fee. This will be required to be paid at the time of the next consultation.

Patient's Name: _____ DOB: ____/_____/_____

Signed: _____ Date: ____/_____/_____

Parent/Carer's Name: _____
If signing for a child under the age of 16

Medicare Card sighted by reception staff ☐ **YES**