CRANBOURNE
EAST MEDICAL CENTRE

NEW PATIENT INFORMATION FORM

GENERAL INFORMATION			
Title	Mr-Mrs-Miss-Ms-Master-Dr-Sir-Prof-Other **(Please circle)**		
Given Names			
Prefered Name			
Surname			
Date Of Birth		**Gender**	
Nationality/Ethnicity			

Australian, Non Indegenous ☐ yes

Aboriginal but not Torres Strait Islander ☐ yes

Both Torres Strait Islander and Aboriginal ☐ yes

Torres Strait Islander but not Aboriginal ☐ yes

RESIDENTIAL ADRESS	
Address	
Suburb	
State/Postcode	

PHONE NUMBER & EMAIL ADDRESS	
Home/work phone	
Mobile	
e mail address	

MEDICARE CARD / *BUPA/ NIB / ALLIANZ / AHM & MEDIBANK*	
Card Number	
Line Number (IRN)	**Expiry Date**

Please put NA if none **HEALTHCARE**		Please put NA if none **PENSION CARD**	
Card Number		**Card Number**	
Expiry Date		**Expiry Date**	

EMERGENCY CONTACT		
First Name		Mr-Mrs-Miss-Ms-Dr-Prof-Sir
Surname		
Phone Number	**Relationship**	

How did you hear about us? Drive Past / Website/ Online Booking/ Signage/ Other

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NEW PATIENT INFORMATION FORM			
HEALTH HISTORY			
Allergies (Please circle)	Yes	No	
List Allergy/Allergies			
Smoking Status	[ ] Yes	[ ] No	[ ] Quit (since:)
	If yes, how many per day?		
Drink Alcohol?	[ ] Yes	[ ] No	
	If yes, how often?	Always - Sometimes - Socially - Rarely	
dical histories below? If yes please tick (✔):			
	[ ] **Asthma** [ ] **Diabetes** [ ] **Kidney Disease** [ ] **Bowel Cancer** [ ] **Epilepsy** [ ] **Other:**	[ ] **Breast Cancer** [ ] **High Blood Pressure** [ ] **Heart Problems** [ ] **Stroke**	

[ ] REMINDER SYSTEM
I wish to participate in SMS reminders for appointments, health initiative reminders, immunisations, annual health checks, and pap smears.

PRIVACY
I consent for messages to be left on my telephone or mobile answering or message bank regarding matters involving my health.

CONSENT
I consent to the collection, use and handling of my information by the practice for the purposes set out above.

Cranboune East Medical centre collects your personal details and health information to ensure we deliver the best possible healthcare service. Patients are entitled to access their information at any stage by contacting the practice or their GP. Your health information may be disclosed to other organisations over the course of your treatment and these instances will be discussed with you if required. Failure to provide accurate and comprehensive information could negatively affect your healthcare. If you have any concerns regarding your privacy, please contact the practice.

Signature……. Date____/____/_____