CRAIGROSSIE CLINIC NEW PATIENT FORM

Patient details:
Title: MR/MRS/MS/MISS/MSTR Surname:_____

Given Names:_____

Date of birth:_____

Male Female Non-Binary Gender Diverse Transgender Different Identity

Are you of Aboriginal origin: Yes or No Torres Strait Decent: Yes or No

Country of Birth: _____ Cultural/Ethnicity Background: _____

Marital Status: Single Married De facto Separated Divorced Widowed

Medicare Number _____ Ref: Exp Date:

Veteran Affairs Number: _____

Occupation: _____ Blood Type (if known)_____

Home Address: _____
_____ Postcode:_____

Phone: Home: _____ Work: _____

Mobile: _____ Email: _____

Emergency Contact
Name: _____ Relationship to you: _____Ph: _____

Next of kin: Name:_____ Relationship to you: _____ Ph: _____

Social/Family Structure:

Allergies/Cautions/Severity:

Past History

Smoking: Yes No If ex-smoker date ceased:

Family History

We send out SMS appointment reminders. If you do not wish to receive these reminders, please indicate - NO

If you would like to be part of our reminder/recall system, please indicate: YES NO

If you are agreeable to have your medical history forwarded to medical specialists as required. Please indicate: YES NO

***STANDARD APPOINTMENT TIMES ARE 15 MINUTES DURATION. LONGER APPOINTMENT WILL INCUR AN ADDITIONAL FEE:- PLEASE SPEAK TO RECEPTIONIST**

DO YOU AGREE TO HAVE YOUR eHEALTH RECORD UPLOADED TO myhealthrecord.gov.au YES NO If no, please indicate on your MyGov account, as otherwise it will be uploaded automatically.
(this enables communication between you GP and Specialist/Hospital Admissions/Immunisation records)