MILESTONE MEDICAL
NEW PATIENT REGISTRATION FORM

PATIENT DETAILS

- *Title* ……
- *First Name* ……
- *Surname* ……
- *Known as* ……
- *Date of Birth* ……

CONTACT DETAILS

- *Mailing Address* ……
- *Suburb* ……
- *Post Code* ……
- *State* ……
- *Mobile Number* ……
- *Home Number* ……
- *Work Number* ……

HEALTH INSURANCE

- *Medicare No* …… *Reference* …… *Expiry* ……
- *Private Health Fund Name* …… *Membership No* ……
- *DVA Number (if applicable)* ……

GENERAL PRACTITIONER

- *Referring Doctor* ……
- *Usual General Practitioner* ……

PAYMENT *– Payment is required at the time of consultation. We accept cash and credit/debit cards. We do not accept cheques, AMEX or Diners. This practice does not Bulk Bill. Please discuss anticipated costs with the reception staff prior to seeing the Doctor.*

Patient Signature ……