



Milton Clinic

Level 1, Centro Milton,
36 Baroona Road,
Milton, QLD 4064
Tel: (07) 3369 5133

New Patient Details

Section: 1 Please complete the following: (check boxes mark with ☒)			
1	Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Master <input type="checkbox"/> Miss <input type="checkbox"/> Ms		
2	Surname:	Given Names:	
3	Address:		
4	Suburb:	State:	Postcode:
5	Home Phone Number: ()	Business Phone Number: ()	Mobile Phone Number:
6	Email Address:		
7	Date of Birth: / /	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
8	Medicare Number:	Expiry Date: / /	
9	Number in front of name on Medicare Card:		
10	Pension Number:	Expiry Date: / /	
11	DVA Number:	Expiry Date: / /	
12	Health Care Card:	Expiry Date: / /	
13	Private Health Fund / Membership Number:		
14	Work Status/Occupation:		
15	Who do you wish to be contacted in the case of an emergency	Name:	
	Suburb:	State:	Postcode:
	Home Phone Number: ()	Business Phone Number: ()	Mobile Phone Number:
16	Please List Any Allergies:	1.	2. 3.
17	Do you wish to identify with any cultural group :		<input type="checkbox"/> Yes <input type="checkbox"/> No
18	I have read & understood the Clinics Privacy Policy :		<input type="checkbox"/> Yes <input type="checkbox"/> No
19	I certify the information on this form to be true and correct:		<input type="checkbox"/> Yes <input type="checkbox"/> No

Section: 2 Person responsible for this account (only complete this section if different from patient details)			
1	Surname:	Given Names:	
2	Suburb:	State:	Postcode:
3	Home Phone Number: ()	Business Phone Number: ()	Mobile Phone Number:

Section: 3 How did you hear about Milton Clinic?	
1	<input type="checkbox"/> Internet <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Shop Signage <input type="checkbox"/> Family/Friend <input type="checkbox"/> www.miltonclinic.com.au <input type="checkbox"/> Other (please state)

Signature: _____ Date: / /

Name (print): _____