SHILOH MEDICAL PRACTICE

120 Edwardes Street
PO Box 172
DENILIQUIN NSW 2710
Ph (03) 58817597
Fax (03) 58816831
Email manager@shilohmedical.com

REQUEST TO BECOME A PATIENT

As this practice has a waiting list for new patient admissions we ask that you fill out this information sheet in advance so that we have your details on file prior to a vacancy appearing on the waiting list. You will be phoned by staff if a vacancy becomes available.

DATE: _____

NAME _____ DATE OF BIRTH: _____

ADDRESS _____

PHONE _____ MOBILE _____

MEDICARE No _____ REF No _____ Exp date _____

PENSION/HEALTHCARE/VETERAN AFFAIRS (please circle) No: _____ Exp Date _____

PRIVATE HEALTH FUND _____ MEMBER No _____ EXP _____

OCCUPATION _____ ATSI/OTHER CULTURE/ETHNICITY _____

ALLERGIES _____

CURRENT DOCTOR _____

MEDICAL HISTORY _____

_____

DIABETIC YES/NO IDDM/NIDDM **ASTHMA** YES / NO

CURRENT MEDICATION _____

_____

_____

OFFICE USE ONLY

RECEIVED BY	ACCEPTED	DECLINED	STAFF MEMBER

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DATE_____

TO WHOM IT MAY CONCERN

_____

_____

_____

The following patient/s would like their Medical Records transferred to Shiloh Medical Practice Pty Ltd.

NAME _____DATE OF BIRTH _____

FAMILY MEMBERS

_____ _____

_____ _____

_____ _____

ADDRESS

_____

We would appreciate you providing us with their complete records including paper documents and records on Medical Director or similar program in which you use.
Please advise the patient if files will not be released before a payment is made.

Could you please include the dates of most recent GPMP/TCA and/or review (721, 723 and 732) if applicable.

Kind Regards

_____ _____

Shiloh Medical Practice Patient Signature

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Patient Consent – Third Party

Staff at Shiloh Medical Practice are required to seek patient consent for the presence of a third party during their consultation. A patient is entitled to either consent to, or decline the presence of a third party.

Please complete this form to indicate your consent/decline to the presence of a third party during your consultation.

Patient Consent Details:

I, _____
(patient's first/given names) *(Surname)*

☐ have requested the presence of my spouse, family member, guardian, friend, carer, interpreter or chaperone, during my consultation.

OR

☐ understand that the general practitioner has requested presence of a third party being an interpreter, medical or allied health or nursing professional or student, general practice registrar or chaperone, during my consultation.

AND

Consent to having a third party present during my consultation: _____
(signature)
(date)

OR

Decline having a third party present during my consultation: _____
(signature)
(date)