SHILOH MEDICAL PRACTICE

120 EDWARDES STREET
PO BOX 172
DENILIQUIN NSW 2710

PH (03) 58817597
FAX (03) 58816831

EMAIL ADMIN@SHILOHMEDICAL.COM.AU

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.

FULL NAME: ..... DATE OF BIRTH: ...../...../..... SEX: .....

ADDRESS: .....

PHONE NO.: ..... MOBILE NO: ..... E-MAIL: .....

PREFERRED PHARMACY: ..... E-MAIL: .....

OCCUPATION: ..... NATIONALITY: .....

DO YOU IDENTIFY AS ABORIGINAL OR TORRES STRAIT ISLANDER: YES ☐ NO ☐ .....

NEXT OF KIN: FULL NAME: ..... PHONE NO.: .....

RELATIONSHIP: ..... ADRESS: .....

EMERGENCY CONTACT: tick if same as above: ☐ **OR** FULL NAME: .....

PHONE NO.: ..... RELATIONSHIP: ..... ADRESSS: .....

MEDICARE NO: ..... REF NO.: ..... EXP DATE: ..... / ...../ .....

PENSION ☐ HEALTHCARE ☐ VETERAN AFFAIRS ☐ CONSESSION ☐ (please TICK)

CARD NO: ..... EXP. DATE: ...../ ..... / .....

PRIVATE HEALTH FUND MEMBER NO: ..... EXP DATE: ...../ ...../ .....

CURRENT DOCTOR: ..... MEDICAL HISTORY: .....

.....

CURRENT MEDICATIONS: .....

.....

ALLERGIES: .....

FOR OFFICIAL USE ONLY

RECEIVED BY: ..... DATE: ...../ ...../ ..... ACCEPTED ☐ DECLINED ☐ STAFF MEMBER: .....

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DATE: ..... / ..... / .....

TO WHOM IT MAY CONCERN

.....

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

FULL NAME: ..... DATE OF BIRTH: ..... / ...../ .....

FAMILY MEMBERS:

.....

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.....

.....

ADDRESS: .....

We would appreciate you providing us with their complete medical records, including paper documents and records on Medical Director or similar program which you use.

Please advise the patient if files will not be released before a payment is made.

If you are providing patient records on a disc please save them in PDF, HTML and XML format to enable ease of transfer.

Could you please include the dates of most recent: GPMP/TCA 721, 723 Review (732) Health Assessments (703/705 ATSI health assessment.

Kind Regards,

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Shiloh Medical Practice Patient Signature