



120 Edwardes Street
 PO Box 172 DENILQUIN NSW 2710
 Ph (03) 5881 7597
 Fax (03) 5881 6831
 Email :

manager.accounts@shilohmedicalpractice.com.au

REQUEST TO BECOME A PATIENT FORM

PLEASE FILL OUT REQUEST TO BECOME A PATIENT FORM AND A SIGNED MEDICAL RELEASE RECORDS FORM AND RETURN BY EMAIL LISTED ABOVE OR TO RECEPTION DESK.

BY RETURNING, PLEASE NOTE THAT YOU AGREE TO THE BELOW STATEMENTS

- **I CONSENT TO BEING CONTACTED BY PHONE, SMS OR EMAIL REGARDING MY REQUEST.**
- **I UNDERSTAND THAT MY APPLICATION FORM DOES NOT GUARANTEE ACCEPTANCE AS A PATIENT.**
- **I UNDERSTAND THE RELEASE OF MEDICAL RECORDS FORMS WILL ONLY BE SENT IF I AM ACCEPTED AS A NEW PATIENT AT SHILOH.**



PERSONAL DETAILS

NAME:
 PREFERRED TITLE: DATE OF BIRTH: EXPIRY DATE:
 ADDRESS:
 MOBILE No HOME PHONE:
 E-Mail:
 OCCUPATION:
 PENSION/ HEALTHCARE/ VETERAN AFFAIRS (please circle) No: EXPIRY DATE:
 PRIVATE HEALTH FUND: MEMBER No: EXPIRY DATE:
 CURRENT MEDICAL PRACTICE or GP:
NEXT OF KIN:
 FULL NAME: HOME PHONE:
 RELATIONSHIP: MOBILE PHONE:
EMERGENCY CONTACT:
 FULL NAME: HOME PHONE:
 RELATIONSHIP: MOBILE PHONE:
 MEDICARE No: REF No: EXPIRY DATE:

THE FOLLOWING INFORMATION WILL ASSIST US IN THE PLANNING AND PROVISION OF THE BEST POSSIBLE CARE:

NATIONALITY: COUNTRY OF BIRTH:
 LANGUAGE SPOKEN AT HOME: OTHER LANGUAGE SPOKEN:
 DO YOU REQUIRE AN INTERPRETER? No Yes
 ABORIGINAL OR TORRES STRAIT ISLANDER: NO YES
 MEDICAL HISTORY:
 CURRENT MEDICATION:

DO YOU GIVE CONSENT TO THE FOLLOWING:

- YES NO -CAN WE SMS YOU REGARDING AN APPOINTMENT, RECALL OR REMINDER?
- YES NO -CAN WE LEAVE A MESSAGE WITH YOUR NEXT OF KIN OR EMERGENCY CONTACT?
- YES NO -CAN WE LEAVE A MESSAGE ON YOUR MESSAGE BANK REGARDING AN APPOINTMENT?

Privacy Statement:

We value your privacy . All information about you is kept in the strictest confidence and we operate in accordance with the *Privacy Act (1988)* and *Privacy Amendment (Enhancing Privacy Protection) Act 2012*. We are committed to protecting your privacy and ask for your consent for the use and disclosure of your personal health information as required during your health care.

For further details about how we collect and use your health information to support your care, please visit our website and review the document "How We Use Your Health Information".

I CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION AS REQUIRED FOR MY HEALTH CARE.

Full Name of patient:..... Date:.....

Signature of patient:.....

If required:

Name of Guardian of patient:.....

Signature of Guardian of patient:..... Date:.....

OFFICE USE ONLY



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Date:

To whom it may concern:

The following patients would like their medical records transferred to Shiloh Medical Practice Pty Ltd.

Name: Date of birth:

Address:

Family members

Name: Date of birth:

Name: Date of birth:

Name: Date of birth:

We kindly request that you provide the complete medical records for this patient, including all paper documents and electronic files, in PDF format, to manager.accounts@shilohmedicalpractice.com.au

Please also inform the patient if any fees apply for the transfer of their medical records.

Could you please include the dates of most recent:

- GPMP/TCA,
- GPMP/TCA Review
- Health Assessments
- ATSI Health assessment

Thank you,
Kind Regards,

.....

Shiloh Medical Practice

Patient Signature