**Wilton Clinic**

Merrymeeting Shopping Centre

Rathnew, Co Wicklow, A67KP52

T: (0404) 31 551

**www.wiltonclinic.ie**

**NEW PATIENT REGISTRATION FORM**

**Surname:** **Forename:**

**Address:**

**EIRCODE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Gender\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PPS Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone:**  **Mobile:** \_\_\_\_\_\_\_\_\_**Home:**

**E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Card / Under 6 Card / Doctor Visit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Private Health Insurance:** **Yes/No** **Provider**:

**Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Next of Kin** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(in case of emergency)**

**Phone Number:** **Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Previous GP Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Doctor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Children** | | |
| **Full Name** | **Relationship to You** | **Date of Birth** |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |

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**Text Messaging Consent Form**

From time to time, Wilton Clinic General Practice may wish to contact you by text – for example to remind you about an upcoming appointment or to inform you that your test results are back.

Please read the notes below carefully before you sign below to give or withhold your consent

* Test messaging is a one-way service. There is no reply facility to enable patients to send text messages back to the practice. If you wish to communicate with staff please either make an appointment, call 0404 31551 or send in a written request.
* Text messages are generated using a secure facility. They are transmitted over a public network onto a personal mobile phone and so may not be secure. However, we will only send text messages to let you know that your results are normal or to ask you to contact us. You may also receive important personal healthcare reminders such as availability of the flu vaccine, or that your baby’s immunisation are due. Private medical results or information will never be communicated via text message.
* Text reminders will not be routinely sent for all appointments. The responsibility of attending and cancelling appointments rests with you.
* We advise that you password protect your phone, read and then delete GP texts.
* If your mobile number changes or you lose your mobile phone, it is your responsibility to let us know your new mobile number.
* You can of course cancel the text message facility at any time by calling us on 0404 31551 or by sending in a written notification.
* Please also be aware that it is practice policy not to communicate with patients via email except for provision of electronic copies of receipts.
* Please remember it is important to advise us if your contact details change. If you don’t let us know your mobile number or email address has changed we may inadvertently send information to an incorrect person.
* I agree to updating the practice if my contact details change please tick box

**I Consent to: I Do NOT Consent to:**

*Wilton Clinic General Practice contacting me by text message for patient care and appointment reminders. This includes any children under my guardianship.*

**I Consent to: I Do NOT Consent to:**

*Wilton Clinic General Practice contacting me by text message in relation to Investigation results. . This includes any children under my guardianship.*

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Request of medical records**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To Dr: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Re: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Doctor

The above patient has decided to register with this practice.

I would be grateful if you could send me a copy of their medical records. Signed patient consent in accordance with Data Protection Regulation has been provided below.

To securely transfer patient files electronically our secure healthmail address is [wiltonclinic.gp@healthmail.ie](mailto:wiltonclinic.gp@healthmail.ie)

Many thanks,

Yours sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Doctor Signature**

**Patient Section**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (PRINT NAME)

Consent to the release of my medical records to Wilton Clinic General Practice

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient (or Guardian)**

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**Patient Data Consent Form**

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**Department of Employment Affairs and Social Protection**

**Data consent form**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PPSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I the undersigned, authorise Wilton Clinic General Practice to transfer my personal data for the purpose of claiming and proving eligibility to illness/Disability Schemes to the Department of Employment Affairs and Social Protection. My consent remains valid for all future transactions with the Department unless I revoke it in writing.

I understand that I may revoke this consent at any time by contacting the Department or by informing the medical practice in writing.

**Signature of Patient: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature on behalf of Wilton Clinic General Practice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**