# LIFETIME FAMILY PRACTICE

## Dr Lucia Maior

IMC 320468, GMS 70001
RIDGE HOUSE, SHANGANAGH ROAD
BALLYBRACK, CO DUBLIN A96 N8W7
Tel: 01 2824811 ; Fax: 01 5511398

Dr Aisling McGreal IMC 400663 Dr John FitzGerald IMC 301977
Dr Ariane Gill IMC 402880 Nurse Agnieszka Kotas

**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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Text Messaging Consent Form

From time to time, Lifetime Family Practice may wish to contact you by text – 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 01 282 4811, 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 is due. Private medical results or information will never be communicated via text message.
- 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 01 282 4811 or by sending in a written notification.
- Please also be aware that it is practice policy not to communicate with patients via email.
- 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:

*Lifetime Family Practice contacting me by text message for patient care.*

☐ I Consent to: ☐ I Do NOT Consent to:

*Lifetime Family 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: lifetimefamilypractice.gp@healthmail.ie

Many thanks.

Yours sincerely,

_____

Doctor Signature

Patient Section

Date: _____

I _____ (PRINT NAME), consent to the release of my medical records to Lifetime Family Practice

_____

Signature of Patient (or Guardian)

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## Patient Data Consent Form

An Roinn Tithíochta,
Rialtais Áitiúil agus Oidhreachta
Department of Housing,
Local Government and Heritage

**Department of Employment Affairs and Social Protection**

**Data consent form**

**Name:** _____

**PPSN:** _____

**DOB:** _____

I the undersigned, authorise Lifetime Family 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 Lifetime Family Practice:**_____

**Date:** _____