Patient Registration and Medical Summary Form

Dr. John Bannon & Dr Simone Haase, Lir Medical,
Mullingar Healthcare Complex, Austin Friar St., Mullingar,
Co. Westmeath. Phone 0449305964
info@drbannonmullingar.ie

In order to provide for your care we need to collect and keep information about you and your health in your personal medical record. Please complete the following form. The information will be used to create your personal medical record on the practice computer.

Our practices are consistent with the Medical Council guidelines and the privacy principles of the Data Protection Acts. For further details please see our Practice Privacy Statement

PART 1-PERSONAL DETAILS

Surname:_____

First name(s): _____

Date of birth:_____/_____/_____

Mr./Mrs./Ms./Other_____ **Gender:** Male/Female/

Address: _____

_____

eircode:_____

Phone-Numbers: Home:_____
Mobile:_____ Work:_____

GMS/DVC number_____ exp date:_/__/_

Previous GP Name and Address:

_____

_____

_____

Pharmacy:

_____

Children (under 16). Patients over 16 must complete a separate form.

Name:_____ DOB: __/__/____
PPS Number:_____
Name: _____ DOB:__/___/____
PPS Number:_____
Name:_____ DOB:__/__/___
PPS Number:_____
Name: _____ DOB:__/__/_____
PPS NUMBER_____

PPS NUMBER IS OPTIONAL, however, to avail of certain governmental schemes (eg. Social welfare certs, Work certs, Mother and Child Maternity Scheme, Cervical Check, Adult and Childhood Vaccinations, Covid referral) It will be necessary for you to provide us with your PPSN. Please see attached consent information.
For a list of our services, useful documents and links to HSE and Social Welfare please check our web page at www.drbannonmullingar.ie

Practice Privacy Statement available on request.

PART 2- HEALTH HISTORY

Allergies:

_____

_____

Medical history:_____

_____

_____

Surgical history:

_____

_____

_____

Current medications:

If you are unsure you could bring your empty pill boxes with you or get a printout from your pharmacist.

_____

_____

_____

_____

Next of kin: _____
Relationship: _____
Phone/Mobile: _____
Permission to contact: Yes/ No

Further Information: **The following information is not essential** but may be of use to your doctor when they are diagnosing a problem or deciding on a treatment plan for you;
Marital status: _____
Occupation: _____
Ethnicity:

A- White: Irish / Irish Traveller / Other White Background
8- Black or Black Irish: African / Other Black Background
C- Asian or Asian Irish:Asian Background
D- Other including Mixed Background

PART 3- PATIENT STATEMENT

Signature._____
Date: _____

Lir Medical

Consent Form
Patient Phone/Text/email Messaging

Full Name: _____

Date of Birth:_____ **(over 16's only)**

Address:_____

_____

_____

Mobile Phone:_____ **House Phone:**_____

Email Address: _____

Please circle each option to consent: **Phone: Yes/No** **Mobile: Yes/No** **email: Yes/No**

1. I consent to the practice contacting me by phone/text/email for the purpose of receiving appointment reminders and notifications which may be relevant to me. BLOOD RESULTS AND MEDICAL INFORMATION WILL NOT BE SENT BY TEXT/PHONE/OR EMAIL.
2. I acknowledge that appointment reminders by phone/text/email are an additional service and that these may not take place on all occasions and that the responsibility of attending appointments or canceling them still rests with me. I understand that if I am not able to keep an appointment I will phone the surgery to cancel.
3. Text messages and emails are generated using a secure facility but I understand that they are transmitted over a public network onto a personal telephone/computer and as such may not be secure.
4. All patients have the right to change their minds and have this service stopped. If you no longer wish to receive these reminders please notify reception at 0449305964 or email info@drbannonmullingar.ie.
5. The surgery does not offer a reply facility to enable patient to respond to texts directly.
6. I agree to advise the practice if my phone/mobile number or email address changes or is no longer in my possession.

Signed

Date

Lir Medical, Dr John Bannon & Dr Simone Haase, Mullingar Healthcare Complex, Austin Friar Street, Mullingar, Co. Westmeath. Phone: 0449305964 email: info@drbannonmullingar.ie

Lir Medical

Patient consent for processing of health data

To assist with your care, Dr Bannon and Dr Haase will need to collect personal data about you. This information will include details of your health and your treatments.

We may also need to record additional information that while may not seem to relate directly to your health it would help in our treatment of you. Examples of this kind of information would include things like your age, gender, marital status, number of children you have, your nationality, your employment status, religion, prison sentences. Our policy is only to collect and record information about you that helps in your treatment.

Declaration.

- I understand my health information will be seen or shared only with medical and administrative staff involved in my care or where Dr Bannon and Dr Haase's practice is required to do so by law.
- I understand that for the purposes of my treatment administrative staff may have to access my health data. Reasons for this access would include the re-issuance of prescriptions, the opening of letters and recording of information from hospitals about me, downloading and saving in my file results from laboratories, typing of letters to hospitals and other similar health related issues.
- I understand that all of the practice staff sign a confidentiality agreement that binds them not to disclose my details to any unauthorised persons not involved in my care.
- I understand that any health data shared outside of the practice for the purposes of my health treatment will normally be limited to information related to a particular treatment and not my entire file.
- I understand that my health data will be stored primarily on a secure database operated by a specialist company called Clanwilliam Health and I understand that Clanwilliam Health are only allowed process my health data under the practice's instructions.
- I understand the law provides that in certain instances personal health information can be disclosed, e.g. in the case of some infectious diseases.
- I understand that Dr Bannon and Dr Haase's practice will only release information to, for instance solicitors or insurance companies, at my express request.
- I understand that I can withdraw consent for processing of my personal health data at any time.

I *WRITE NAME HERE thereby freely consent for Dr John Bannon and Dr Simone Haase to process my personal data, include health information, for the purpose of my on-going health care treatment in accordance with what I understand above.

Signed Patient _____ Print name: _____

Date of Birth _____

Or Guardian _____

Today's Date: ____/____/____/

Dr John Bannon
'General Practitioner
MB BCH BAO DCH MICGP
IMCN 16148

'Dr Simone Haase
General Practitioner
IMCN 123491

Lir Medical

Mullingar Healthcare Complex. Austin Friar Street, Mullingar, Co. Westmeath, N91 ED2H
Phone:0449305964
info@drbannonmullingar.ie

Date: __/__/_____

To: _____

Address:

_____

Dear Dr.

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 consent in accordance with the Data Protection Acts has been provided below.

Yours Sincerely

_____ _____

Dr John Bannon

IMC 16148

Dr Simone Haase

123491

PATIENT SECTION

DATE: _____

I _____ (Print Name), consent to the release of my medical records to Lir Medical.

_____

Patient Signature.

Patient Data Consent Form

An Roinn Gnóthaí Fostaíochta
agus Coimirce Sóisialaí.
Department of Employment Affairs
and Social Protection.

Department of Employment Affairs and Social Protection -

Data consent form

Name: _____

PPSN: _____

DOB: _____

I the undersigned authorsie Lir Medical Mullingar practice to transfer my personal data for the purposes 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 medical practice: _____

Date: ----------