Scally McDaid Medical Practice

Dr James McDaid, Dr Dara Scally & Dr Ciaran Roarty
Level 1, Scally Place, Justice Walsh Road, Letterkenny, Co. Donegal F92 DPX8
Phone: 07491 64111 | Fax: 07491 64112 | www.scallys.ie

New Patient Registration Form

Please complete the following this form using capital letters. Declaration and consent must be signed on page 2. Please sign at the bottom of page 3 to have your notes transferred if you are moving from another GP.

Surname:_____ First Name:_____

Male: ☐ Female: ☐ (*Please tick one)* Date of Birth: ____/____/_____

Address:_____

_____

Eircode:_____ Tel No:_____ Mobile: _____

Next of Kin:_____ Relationship:_____ Next of Kin Contact No:_____

PPSN:_____ Email Address:_____

Medical card: Yes☐** No☐ Medical card number: _____ (*if applicable)*

*** Please ensure you complete and sign the change of Doctor form on page 4 to have your/your family's medical card changed over to this practice. We will process this application on your behalf.*

Previous GP Name and Address: _____

_____

Reason for leaving previous GP:_____

_____

Do you have any allergies :_____

Medical Conditions:_____

Current Medications: _____

When the practice receives the completed registration form, it will make a computer record for the named applicant.

Scally McDaid Roarty Medical Practice will treat all personal information and data you provide as part of this application, as confidential and store it securely.

Declaration and Consent

I am applying to be a new patient of Scally McDaid Roarty Medical Practice

I declare that the information I have given is correct to the best of my knowledge.

Should there be any change to the above, I will contact Scally McDaid Roarty Medical Practice.

I agree that the pharmacist may contact Scally McDaid Roarty Medical Practice regarding prescribed medicines from time to time.

I give permission to Scally McDaid Roarty Medical Practice to contact me via phone, text message and email. *

I give consent to register to Scally McDaid Roarty Medical Practice's online booking and prescription ordering system:

- I give permission to Scally McDaid Roarty Medical Practice for my data to be stored and used for the purposes of online appointment booking and prescriptions *
- I consent to having this website store my submitted information so they can respond to my inquiry.

GDPR Agreement *

If it applies, I confirm that I am the parent or legal guardian of the named applicant, and I give consent on their behalf. Relationship to applicant: _____

Your signature: _____ Block capitals: _____

Please note that registration is not complete until you have been notified by the practice.

Acceptance to the practice is dependent on availability

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To:_____

_____

Re: _____ DOB: ___ / ___ / ___

Address: _____

_____

Name: _____ DOB ___ / ___ / ____

Name: _____ DOB ___ / ___ / ____

Name: _____ DOB ___ / ___ / ____

Dear Dr _____,

The above patient(s) request that their medical care be transferred to me. I would be obliged if any medical records or copies of same could be forwarded to me at the above address. I attach the above patient's consent and their agreement to be responsible for any cost involved in copying or forwarding notes. Notes can also be forwarded to us via Healthmail at scallymcdaidmedicalpractice.gp@healthmail.ie .

Many thanks for your assistance.

Yours sincerely,

_____

Dr Dara Scally, Dr James McDaid, Dr Ciaran Roarty

I consent to my/my family's medical notes being forwarded to Scally McDaid Medical practice at the above address and to be responsible for any costs incurred.

Signed _____ Date ___/___/___

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Medical Card/GP Visit Card
Change of General Practitioner (GP) Form

The steps are:

1. Carefully fill in all sections on this form
2. Bring the form to the GP of your choice to complete the 'Acceptance of Eligible Person' section
3. Post the completed form to:
   Client Registration Unit, PO Box 11745, Dublin 11. LoCall: **1890 252 919**
4. On receipt of your completed form, your Change of GP request will be processed and a replacement Medical Card(s) or GP Visit Card(s) will be issued to you and your family.

APPLICATION TO CHANGE GP

I wish to change my choice of GP under the Medical Card/GP Visit Card Scheme. Please arrange to transfer me and all family members listed below to the panel of Dr_____, who has signed the 'Acceptance of Eligible Persons' section of this form.

Name: _____

Address: _____

_____

Date of Birth: _____

PPS No: _____

Medical Card No: _____

List all family members that wish to change to Dr:_____(name)

1. _____PPS No:_____
2. _____ PPS No:_____
3. _____ PPS No:_____
4. _____ PPS No:_____
5. _____ PPS No:_____
6. _____ PPS No:_____
7. _____ PPS No:_____

I confirm that I am authorised to make application for a Change of GP on behalf of all persons listed above and I do so with their knowledge and consent

Signature: Date: