Patient / Client Registration Form

Office Use Only:
Employee initials;

PLEASE USE BLOCK CAPITALS

FIRST NAME: _____ **MIDDLE NAME:** _____

SURNAME: _____ **DATE OF BIRTH:** _____

ADDRESS: _____

_____ **Eircode:** _____

PHONE NO: _____ **OCCUPATION:** _____

EMAIL: _____

How did you hear about us? Friend / Advertisement / GP / Family member / Student Union / Health board / Other? _____

For the purposes of **CERVICAL CHECK** and other **HSE** Services:

PPSN: _____ **CSPID NO.** ***(Found on CervicalCheck letter)***: _____

MOTHERS MAIDEN NAME: _____

Are you a **MEDICAL CARD** holder? (Valid in our ***Coolock Centre ONLY*** but can be used as an identifier for other services in the Dublin Well Woman Clinics)

MEDICAL CARD NO: _____ **EXPIRY DATE:** _____

Are you a **STUDENT?** YES or NO ***(If Yes please let us know your student card # & expiry date)***

STUDENT CARD NO: _____ **EXPIRY DATE:** _____

Have you been a patient of the Well Woman Centre in the past five years? ☐ **YES** ☐ **NO**

CONSENT:

I **consent** to receive SMS text messages for appointment reminders. ☐ **YES** ☐ **NO**

I **consent** to receiving emails for purposes of medical services (such as test results). ☐ **YES** ☐ **NO**

I **consent** to the information I have provided to the Dublin Well Woman Centre, being used in order to carry out its various functions and services, including scheduling appointments, ordering tests, hospital referrals, sending correspondence, accounting and reporting requirements for HSE funded services and administering our annual Patient Satisfaction survey. (Read-only policies can be requested from reception or can be viewed in the *patient hub* at www.wellwomancentre.ie)

I have read and understand the nature of the data which is collected by the Dublin Well Woman Centre, the purposes for which the data may be used, the persons to whom data may be disclosed and I understand my rights as prescribed under the General Data Protection Regulation in relation to my personal data.

If you are unable to print and sign this form, please enter your name in block capitals below

PATIENT SIGNATURE: _____ **DATE:** _____