DAVENAL HOUSE SURGERY PARTNERSHIP

PATIENT CONTACT DETAILS

NAME: _____

ADDRESS: _____

_____

_____

POSTCODE: _____

HOME TELEPHONE NUMBER: _____

MOBILE TELEPHONE NUMBER: _____

EMAIL ADDRESS: _____

Please tick as appropriate:

MOBILE PHONE PERMISSIONS:

☐ I agree to Davenal House Surgery Partnership contacting me via text message regarding appointment reminders.

☐ I agree to Davenal House Surgery Partnership contacting me via text message regarding cancelling appointments.

☐ I agree to Davenal House Surgery Partnership contacting me via text message regarding vaccinations.

☐ I DO NOT agree to Davenal House Surgery Partnership contacting me via text message.

EMAIL PERMISSIONS:

☐ I agree to Davenal House Surgery Partnership contacting me via my email address regarding appointment reminders.

☐ I agree to Davenal House Surgery Partnership contacting me via my email address regarding cancelling appointments.

☐ I agree to Davenal House Surgery Partnership contacting me via my email address regarding vaccinations.

☐ I agree to Davenal House Surgery Partnership contacting me via my email address regarding test results.

☐ I DO NOT agree to Davenal House Surgery Partnership contacting me via my email address.

Davenal House will not contact you via text message or email to discuss any clinical issues. Any electronic exchange will be recorded on your medical records.