# Colinton Surgery



# Patient Contact Details

|  |  |
| --- | --- |
| **Surname**  | **Date of birth** |
| **First name** |
| **Address**     **Postcode**  |
| **Email address** *(Private email. not shared):*  |
| **Preferred telephone number** *(ideally mobile)*  |

**Text consent**

This allows us to send you reminders of appointments 48 hours in advance and to contact you occasionally regarding your medical treatment.

**I consent to receiving text messages from Colinton Surgery regarding my medical treatment and I understand that it is my responsibility to keep the Practice up to date with my current mobile data. I will be responsible for the security of the information sent by text.**

**I understand and agree with all the above statements:**

|  |  |
| --- | --- |
| Signature | Date |

### *For practice use only*

|  |  |
| --- | --- |
| Patient CHI number | Vision ID number |
| Authorised by  **(#91B)** | Date |
| Date registration letter/email sent  |