Patient registration form and medical summary form

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

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:

Today's Date: ______________

Title: Mr. / Mrs. / Ms. / Other: ___________ Surname name at birth: ____________________________

Surname: _____________________________ First Name: ____________________________________

Date of Birth: ___________________ Gender: Male / Female (Please circle)

Address: ____

Phone Number: Home: ____________Work: __________________ Mobile: ______________________
Do you consent to receiving texts from the practice? Y / N (Please circle Y or N)

Email address: __________________________ (by giving your email you are consenting to receiving emails from the practice)

Marital Status: _______________ Occupation: ____

Country of Birth: __________________ First language: _______________________________________

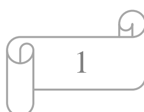
PPSN number: ____
(Note) Your PPSN number is necessary to avail of certain government schemes (e.g. childhood vaccinations, Mother and Child Maternity scheme, Cervical Check, etc).

GMS No (visitor use only – one visit): ______________________ Expiry date: _____________________

Private health insurance /Plan: _________________ Private health Number: _________________________
Previous GP name and address: ____

Would you like to transfer your complete medical care to the practice? Y / N (Please circle Y or N)

OR - attend for a once off consultation? Y / N (Please circle Y or N)



Next of Kin

Name: ____

Address: ____

Relationship to you: _______________ Telephone: ______________________________

(This contact is only used if we cannot contact the patient. It does not in any way give rights to access any medical details on the above named patient.)

Part 2:

Health History

Known allergies: ____

Medical History: ____

____

____

Current Medications (if you are unsure you could bring empty pill boxes with you or get a printout from your last GP or pharmacist):

Medication	Dose	Frequency

Please Note: All children who are registering with the practice must provide a vaccine record.

Part 3:

I (PRINT) _________________________ do / do not want to receive a copy of the Practice Privacy Statement.

Signature ________________________________ Date: ____________________

________________________________ Date: ____________________

Signature as parent / guardian of the above