Patient Registration and Medical Summary Form

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

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:_____

Surname:_____**First name:**__ _____

Known as:_____

Title: Mr/Ms/Mrs/Other:_____

Date of birth:_____**Gender**: Male/Female

Address:_____
_____

Phone: Home:_____

Mobile:_____

Email:_____

I am happy to receive alerts from the practice by:

Mobile phone ☐ Email ☐

This can be a useful form of communication for test results etc

GMS Number:_____**Expiry Date:**_____

Next of kin:

Name:_____

Address:_____

Relationship:_____

Phone:_____

Previous GP name and address:_____

_____

Pharmacy name and address:_____

_____

PPS Number: To avail of certain governmental schemes (eg Social Welfare Certificates, Cervical Check etc) it will be necessary for you to provide us with your PPSN_____

Further Information: The following information is not essential but may be of use to your doctor when they are diagnosing a problem or deciding on a treatment plan for you.
Marital Status:_____
Occupation:_____
Ethnic Origin:_____

Part 2 – Health History

Allergies:_____

_____
_____
_____

Medical History:_____

_____
_____

Surgical History:_____

_____
_____

Current Medications:

If you are unsure you can bring your pill bottles or ask for a printout from your pharmacist

_____
_____
_____

Part 3 – Patient Statement

I _____ (print name) have received a copy of the Practice Privacy Statement.

_____ _____

Signature Date

Finally, we love when new patients decide to attend us – how did you find out about the services we offer?

_____