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. Please complete the following form. The information will be used to create your personal medical record on the practice computer.

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 One

Today's date: ______________________________

Surname: __________ **First name:** ______________

Known as: ______________________________

Title: Mr. /Mrs. /Ms. /Other ____________________

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

Address: ______________________________

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Phone: Home: __________ Work: ______________

Mobile: ____________

I am happy to receive alerts from the practice by:

Mobile ☐ E-mail ☐

GMS number: __________ Expiry date: ____________

Next of kin:

Name: ______________________________

Address: ______________________________

Relationship: ______________________________

Phone: ______________________________

Previous GP name and address: ________________

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Pharmacy name and address: ________________

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PPSN number: To avail of certain government schemes (e.g. Social Welfare certificates, Mother and Child Maternity Scheme, Cervical Check, Childhood vaccinations) it will be necessary for you to provide us with your PPSN number.

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 TWO– HEALTH HISTORY

Allergies: ______________________________

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Medical history: ______________________________

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Surgical history: ______________________________

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Current medications:

If you are unsure you could bring your empty pill boxes with you or get a printout from your pharmacist.

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PART THREE – PATIENT STATEMENT

I ______________________________ (Print Name) have received a copy of the Practice Privacy Statement.

________________________ ______________

Signature Date