Dr. Karen McGrath
santryGP.ie Clinic, Unit 1 Northwood House, Northwood Business Park, Santry, Dublin 9
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Family Registration 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 practice is consistent with the Medical Council guidelines and the privacy principles of the Data Protection Acts. For further details please see our Practice Privacy Statement. **Thank you for completing all parts.**

Date: _____Family Address:_____

Home Tel:_____

Mothers: 1st Name: _____Surname:_____ DOB:____/ _____/____

PPS No:_____Medical Card No: _____Mobile Tel:_____

Country of birth :_____Occupation:_____

Medical History incl Operations:_____

_____

_____

Last Smear (Date):_____ Where:_____

Prescribed medications:_____

_____

_____

_____

Father: 1st Name: _____Surname:_____ DOB:____/ _____/____

PPS No:_____ Medical Card No: _____Mobile Tel:_____

Country of birth :_____Occupation:_____

Medical History incl Operations:_____

_____

_____

_____

Prescribed medications:_____

_____

_____

_____

Previous G.P. Name & Address:_____

Pharmacy Name & Address:_____

I have received a copy of the Practice Privacy Statement. Yes/No

Signed: _____Date: _____

I consent to the surgery contacting me by text-message. Yes/No

Signed: _____Date: _____

I consent to Dr. McGrath contacting my previous GP to obtain copies of my/my family's medical-records. Yes/No

Signed: _____Date: _____

Child 1: 1st Name:_____Surname:_____. DOB:____/_____/____

PPS No: _____ Medical Card Number: _____ Gender: M/F

Country of birth :_____

Medical History incl Operations:_____

_____

Prescribed medications:_____

_____

Child 2: 1st Name: _____Surname:_____
DOB:____/_____/____

PPS No: _____ Medical Card Number: _____ Gender: M/ F

Country of birth :_____

Medical History incl Operations:_____

_____

Prescribed medications:_____

_____

Child 3: 1st Name: _____Surname:_____
DOB:____/_____/____

Country of birth :_____

PPS No: _____ Medical Card Number: _____ Gender: M/ F

Medical History incl Operations:_____

_____

Prescribed medications:_____

_____

Child 4: 1stName: _____Surname:_____
DOB:____/_____/____

PPS No: _____ Medical Card Number: _____ Gender: M/ F

Country of birth :_____

Medical History incl Operations:_____
_____

_____

Prescribed medications:_____
_____