

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 1

Today's date: _____

Surname: _____ **First name:** _____

Known as: _____

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

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

Address: _____

Phone: Home: _____ Work _____

Mobile _____

I am happy to receive alerts from the practice by:

Mobile phone E-mail

GMS number: _____ **Expiry date:** _____

Next of kin:

Name: _____

Address: _____

Relationship: _____

Phone: _____

Previous GP name and address: _____

Pharmacy name and address _____

PPSN number: To avail of certain governmental 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 2 – HEALTH HISTORY

Allergies: _____

Medical history: _____

Surgical history: _____

Current medications:

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

PART 3 – PATIENT STATEMENT

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

Signature

Date