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: ______________________________________

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Phone: Home: ______________ Work_______________

Mobile__________________

I am happy to receive alerts from the practice by:

Mobile phone ❑

Occupation: ____________________________________

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 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.

PPSN No: ______________________________________

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: ____

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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 3-PATIENT SIGNATURE

_________________________ __________________

Signature **Date**

The practice privacy statement is available on request. Please enquire at reception.