PATIENT REGISTRATION

We aim to ensure the highest standard of medical care for our patients. It is not possible to undertake medical care without collecting and processing personal data and data concerning health. Our policy is only to collect and record information about you that helps in your treatment. Our practices are consistent with the Medical Council guidelines and the privacy principles of the Data Protection Acts.

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

Submitting this form does not guarantee acceptance to the practice.

First Name _____ **Surname:** _____

Date of Birth _____ **Gender :** _____

Address _____

_____

Mobile Phone _____ **Home phone** _____

Email _____

PPSN (Optional) _____

In order to provide certain health services, we require your PPSN, e.g. Vaccinations, Cervical Smears, Social Welfare Certs and other National Screening Programmes.

Medical Card Number _____

Next of Kin name: _____ **Relationship to Patient** _____

Next of Kin Contact Phone Number _____

Previous GP Name and Practice Name _____

Previous GP Address _____

Medical History

Details of any existing or previous medical conditions:

PATIENT REGISTRATION

Details of any previous surgical procedures:

Details of any Allergies:

Are you allergic to any medications or Antibiotics? Yes/No

If yes please provide details

Please read carefully and sign below to complete registration form.

- I understand and consent to the practice obtaining my medical records from my previous GP if I am accepted into the practice, for the purposes of my ongoing healthcare and treatment.
- I understand that providing my PPSN is optional and is required for providing certain health services as outlined above.
- I understand and consent to the practice collecting, using, and retaining my personal and medical data to provide the highest of medical care.
- I understand that completing this form does not guarantee acceptance to the practice.

We like to contact our patients by text message regarding appointment reminders, test results, vaccination clinics and other practice updates.

Do you consent to being contacted by text message? Yes _____ No _____

Signature Patient _____ Date _____