

santryGP.ie clinic

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: _____

Mobile number: _____ Home: _____

Email : _____

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 _____

PPS number: _____

To avail of certain governmental schemes (e.g. Social welfare certificates, 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: _____

Country of birth: _____

PART 2 – HEALTH HISTORY

Allergies: _____

Medical history: _____

Surgical history: _____

Current medications:

you can bring your empty boxes or get a printout from your pharmacist.

PART 3 – PATIENT STATEMENT

I confirm I have been offered sight of the Practice Privacy statement, GDPR data processing statement and consent to electronic communications statement.

Signature

Date