# 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