Patient Registration & Medical Summary Form

Part 1

Today's Date:_____

Surname:_____

First name:_____

Known as: _____

Title: (Mr/Mrs/Ms/Dr/Other)_____

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

Address:_____

_____

Telephone: Mobile:_____

Home: _____

I am happy to receive alerts from the practice

via mobile: ☐ Yes | ☐ No

GMS number: _____

Expiry date:_____

Next of Kin:

Name:_____

Address:_____

Relationship:_____

Phone:_____

Previous GP name & address:

_____

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 Medication:_____

_____

Part 3 – Patient Statement

I confirm that I have been notified of the location of the Practice Privacy Statement in the waiting room and also on the practice website www.theparksmedicalcentre.ie

Signature: _____

Date: _____