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

Part 1-Personal Information

Today's date:_____

Surname: _____ **First name:**__ _____

Known as:_____ **Title:** Mr/Ms/Mrs/Other:_____

Date of birth:_____ **Gender**: _____

Address:_____

_____

EIRCODE _____

Phone: Home: _____

Mobile: _____

Email:_____

I am happy to receive alerts from the practice by:

Mobile Phone ☐ E-mail ☐

PPS Number: To avail of certain governmental schemes (eg Social Welfare Certificates, Mother and Child Maternity Scheme, Cervical Check, Childhood Vaccinations, etc) it will be necessary for you to provide us with your PPSN

PPS Number:_____

GMS Number:_____ **Expiry Date: _____**_____

Previous GP name and address:_____

_____

Next of kin:
Name:_____

Address:_____

Relationship:_____

Phone:_____

Children:

Name:_____ Date of Birth_____

Name:_____ Date of Birth_____

Name:_____ Date of Birth_____

Our practice is 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 2 – Health History

Allergies:_____

_____

Medical History:_____

_____

_____

Surgical History:_____

_____

_____

Current Medications:

If you are unsure you can bring your pill bottles or ask for a printout from your pharmacist

_____

_____

_____

Part 3 Patient Statement

I _____(print your name)

have read and agree to the Practice Privacy Statement available at the practice and on the website at……..

I consent to receiving text messages or emails in relation to appointments, blood results or other medical investigation ☐

I am aware that the text messages are generated using a secure facility but I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure

I am aware that I cannot reply by text to any text message received.

I am aware that it is my responsibility to inform Glengarriff Medical Centre if any of my personal details, as in part 1 of this form, change.

I am aware that it is my responsibility to cancel appointments if I am unable to attend.

Signature_____ **Date**_____