Patient Registration Form

Please complete the following form and hand it back to reception where it will be included in your medical record for your doctor's attention.

First Name: _____

Surname: _____

Title: Mr/Ms/Mrs/Other: _____

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

Twin: **Yes /No**

Address:_____

_____

_____

Phone: Home: _____

Mobile: _____

Email: _____

Medical Card Number: _____

Expiry Date:_____

Next of kin:

Name: _____

Address: _____

Relationship:_____

Phone:_____

Previous GP name and address: _____

_____

PPS Number: Where National Health Services are available free of charge we will apply on your behalf e.g. Cervical Check, flu virus vaccination for specific groups etc.

PPSN_____

If you have Private Health Insurance please state your Insurer below:

_____

This General Practice is in partnership with Centric Health

We adhere to Medical Council guidelines and principles of the Data Protection Legislation in relation to all our patient data. Further details are available in our Practice Privacy Statement. Practice Privacy Statement is displayed at www.CentricHealth.ie/PrivacyStatement. We would encourage you to read this or ask a member of our staff for a copy.

Please confirm if you have a preferred Pharmacy. All prescriptions can be submitted directly.

I confirm you can forward all prescriptions directly to:

_____

Please tick with a **Y – Yes** and **N – No**

I consent to receive text messages relating to my care from this practice: ☐

I consent to receive emails relating to my care from this practice: ☐

I consent to receive emails/texts relating to marketing ☐

Please note that text messages and email correspondence can include appointment reminders, test results and other practice information.