Corbally Clinic
Centric Health
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Dr Mary Gray MCRN 005051
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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

Name_____

Date of birth_____

Address_____

_____

Are you a twin? Yes / No

Male/Female (for medical purpose only) _____

Phones: Home_____

Mobile_____

Email_____

PPS number_____

GMS number if applicable_____

Health insurer if applicable_____

Next of kin name_____

Address_____

_____

Phone_____

Relationship_____

Your current or previous GP's name and locality
(if you are new to Corbally Clinic / Grove Island Clinic):

_____
(No contact is made with other doctors without your consent)

This General Practice is in partnership with Centric Health. We adhere to Medical Council guidelines and principles of Data Protection legislation in relation to all our patient's data. Further details are available in our Practice Privacy Statement.

I_____(print your name) have read and agreed to the Practice Privacy Statement on display at the Practice and at www.centrichealth.ie/privacystatement. If I visit another Centric Health Practice, I provide my consent for this Practice to view my medical data for my treatment.
I will inform Corbally Clinic if the information I have provided on this form changes in the future including my address, phone numbers and email address.

Please tick your consent with a Y -Yes or 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 clinical services	☐
Please note that text messages and email correspondence can include appointment reminders, test results and other practice information	

_____ _____
Your signature **Date**