NEW PATIENT REGISTRATION FORM (Page 1)

Surname: _____ Forename(s): _____ Maiden Name: _____

Address: _____

_____

Male/Female _____ Date of birth: ___/____/_____

Phone(H): _____(W)_____Mobile: _____

Do you consent to receiving Text Msgs from the surgery?* Yes_____ No _____

PPS Number: _____ Do you consent to us holding this number?* Yes_____ No ____

*(Permission required under new Data Protection Regulations)

Marital Status: _____ Occupation: _____

Medical Card: YES/NO (If Yes) Medical Card No: _____

Private Health Insurance: YES/NO (IF Yes) Provider: _____

Policy Number: _____

Next of Kin _____ (in case of emergency): Telephone:_____

Nominated Person to collect Results/Prescriptions/Letters on your behalf _____

Previous GP Details (Name & Address): _____

_____

Medical History (ie. were you ever in hospital or do you have any conditions for which you are on treatment):

_____
_____
_____
_____
_____
_____

Surgical History (ie have you ever had an operation – please give dates and details):

_____
_____
_____
_____

FEMALES ONLY – Smear History:

Date of Last Smear: ___/____/_____ Result: _____

Previous Smear Results:

_____
_____
_____

NEW PATIENT REGISTRATION FORM (Page 2)

Regular Medications (please include over the counter medications, inhalers and the pill):

_____
_____
_____
_____
_____
_____

Allergies (Drug/other):

Smoker: Yes: _____ Cigarettes/day Years of smoking: _____

No: _____ Never/Ex Smoker Years since quitting: _____

Alcohol: Yes/No

(If Yes) _____ Units/week (1 pint = 2 units; 1 small glass wine = 1 unit; 1 short = 1 unit)

Family History of Medical Problems (ie illnesses of parents, grandparents, siblings or other relatives)

_____
_____
_____

Family Members: (Spouse/ Partner and Dependents)

NAME D.O.B.

_____
_____
_____
_____
_____
_____

*PLEASE NOTE, WE REQUEST THAT YOU INFORM US OF ANY CHANGE IN YOUR CONTACT/ABOVE DETAILS

THIS PRACTICE DOES NOT TOLERATE ANY FORM OF 'ABUSE' - VERBAL/CYBER ETC. TO STAFF OR A MEMBER OF THE PUBLIC