Contact Us:

Tel: 027 50504 Fax: 027-51988

Email: adminteam@marinomedical.ie

Patient Registration and Medical Summary Form

In order to provide for your care we would 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. Our practices are consistent with the Medical Council Guidelines and the privacy principles of the Data Protection Acts. **http://www.icgp.ie/data**
For further details please see our Practice Privacy Statement

Please complete the following form.

PART 1 – PERSONAL INFORMATION

All details will be strictly confidential

Today's date: _____

Surname: _____

First name: _____

Known as: _____

Title: Mr. /Mrs./Ms./ Other _____

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

Address: _____

_____

Phone: Home: _____ Work _____

Mobile No. _____

I am happy to receive test alerts from the practice by:
Mobile phone ❑ **Land phone ❑**

Nationality: _____

If you require a translator, please bring a companion with you

GMS / NHS number _____ Expiry date: _____

PPSN number: _____

To avail of certain governmental schemes:
(e.g. Social welfare Certificates, Mother & Child Maternity Scheme, Cervical Check, Childhood vaccinations)

Previous GP name & address:

_____

_____

Pharmacy name & address:

_____

Next of kin:
Name: _____

Address: _____

Relationship: _____

Consent for Partner/Spouse/other Named Person
To Collect my Prescriptions/results/referral letters: ☐ yes ☐ no

Named Person: _____

PART 2 – HEALTH HISTORY

All details will be strictly confidential

Please use reverse of this page if you have any other information you require the GP to know

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.

Allergies: _____

Have you suffered from ? (Please tick boxes)	Yes	No
Any heart complaint?	☐	☐
Are you at present taking any medicines or tablets?	☐	☐
Diabetes?	☐	☐
Are you allergic to any medicine or tablets?	☐	☐
Epilepsy?	☐	☐
Any other serious illness?	☐	☐
Chronic bronchitis or asthma?	☐	☐
High blood pressure?	☐	☐

Current medications:
If you are unsure you could bring your empty pill boxes with you or get a printout from your pharmacist.

_____

_____

PART 3 – Patient Statement

I _____ (Print Name)

Signature Date _____

- I **consent** to the practice contacting me by telephone or text message for the purpose of receiving appointment reminders.
- I acknowledge that appointment reminders by text are an additional service and that these may not take place on all occasions and that the responsibility of attending appointments or cancelling them still rests with me. I understand that if I am not able to keep an appointment I will phone the surgery to cancel.
- 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.
- All patients have the right to change their minds and have this service stopped. If you no longer wish to receive these reminders please notify reception.
- The surgery does not offer a reply facility to enable patient to respond to texts directly.
- I agree to advise the practice if my mobile number/address/personal details change or if this is no longer in my possession.

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