WELCOME TO THE PARK CLINIC

PATIENT REGISTRATION 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. Our policies are consistent with the Medical Council guidelines and the privacy principles of the Data Protection Regulations. This practice has voluntarily adopted the requirements of "Processing of Patient Personal Data: A Guideline for General Practitioners". For further details please view our Privacy Statement on our website www.parkclinicathy.ie or access the Guideline at www.icgp.ie/data.

PERSONAL

Surname: ________________ **First name:** __________________________ **Middle Name:** ______________

Address: ____

Date of Birth: __________________ **Nationality:**___________________**Occupation:**__________________

Phone No: Home: ___________________ **Mobile:** _____________________ **Male/Female:** __________

(If female) Maiden surname: ______________________ **Mother's maiden surname:** ____________________

(If a child): Mother's name: _________________ **Father's Name:** __________________________________

GMS Number: ______________________ **Expiry Date:** ______________**PPS Number**_________________

I consent for the Park Clinic to retain my PPS Number on file Y/N

Children: (If any):___________

Child 1 Name_____________________ **Date of birth**____________

Child 2 Name_____________________ **Date of birth**____________

Child 3 Name_____________________ **Date of birth**____________

Child 4 Name_____________________ **Date of birth**____________

I consent to receive alerts and information from the practice by:

Mobile phone Y/N Email Y/N Email Address____

How long are you residing in Ireland? ____

Next of Kin: ______________________________ **Phone Number:** ____________________________________

Next of kin address: ____ **Relationship:** ____________________

Previous GP Name and Address: ____

Pharmacy Name and Address: ____

Allergies: (if known) ____

Please have your relevant medical history available together with a list of your current medication at your first appointment.

PATIENT STATEMENT: I _________________________________ **(Print name) have received a copy of the Practice Privacy Statement. (See** www.parkclinicathy.ie**)**

Signature ___________________________________ **Date** __________________________