

# 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](http://www.parkclinicathy.ie) or access the Guideline at [www.icgp.ie/data](http://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

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](http://www.parkclinicathy.ie))

Signature \_\_\_\_\_ Date \_\_\_\_\_