Oakwood
Medical Clinic

Patient Registration and Medical Summary Form

In order to provide for your care we need to collect information about you and your health in your personal medical record. Please complete the following form. This 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. For further details please see our Practice Privacy Statement.

PART 1

Surname: ___________________________________
First Name: _________________________________
Title: Mr/Mrs/Ms/ Other: _____________________
DOB: _____________ **Gender:** M / F
Address: ____________________________________
____
____

Phone: Home: __________ Work: _____________
Mobile: ______________________________

I am happy to receive alerts from the practice by mobile phone: **Yes / No**

GMS Number: ____________ Expiry: ___________

Next of Kin:
Name: _____________________________________
Address: ___________________________________
____
Phone: ______________________________________
Relationship: _________________________________

Previous GP Name and Address:
____
____

Pharmacy Name and Address: __________________
____

PPS Number: ______________________________
To avail of certain governmental schemes (eg Social Welfare Certificates, Mother and Infant Scheme, Cervical Check, Childhood Vaccinations) it will be necessary for you to provide use with your PPS number.

Further information:
The following information is not essential but may be of use to your doctor when they are diagnosing a problem or deciding a treatment plan for you.

Marital Status: _____________________________
Occupation: _______________________________
Ethnic Origin: ______________________________

PART 2 - HEALTH HISTORY

Allergies: ____________________________________
____
____
____

Medical History:
____
____
____
____
____
____
____

Surgical History:
____
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____
____
____
____

Current Medications:
(If you are unsure you could bring your empty pill boxes with you or get a printout from you pharmacist)

____
____
____
____
____
____

PATIENT CONSENT

I _________________________________ ***(Print Name)***
have received a copy of the Practice Privacy Statement.

_________________________ ________________
Signature **Date**

THANK YOU