Church Street Medical Centre
Moate, Co. Westmeath, N37 H9Y4
Tel.:090 6481130 Fax: 090 6482013
Email: info@churchstreetmedical.ie Healthmail: moatemedicalcentre.gp@healthmail.ie
Web: www.churchstreetmedicalcentre.ie

PATIENT REGISTRATION AND MEDICAL SUMMARY 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. Please complete all sections below in full. The information will be used to create your personal medical record on the practice computer.

Title: Mr / Mrs / Ms / Other: ________ **First Name:** ______________________ **Surname:** ________________________________

Known as: ______________ **Birth Surname:** _________________ **DOB:** __________________ **Male/Female**

Mother's Maiden Name: ___________________ **PPSN:** ____________________ **Occupation:** _________________________

Marital Status: _____________ **Country of Birth:** __________________ **Email:** _____________________________________

Address: ____

____ **Eircode:** ______________

Phone: Mobile ________________________ **Home:** ____________________

Private Health Insurance Details: ____

ID Provided: Yes No **Type of ID:** ___________________ **Proof of Address must accompany this form**

I am happy to receive alerts from the practice by: **Mobile Phone:** Yes / No **Email:** Yes / No

Medical/Doctor Visit Card No: ______________________________ **Expiry Date:** _____________

Next of kin name and address: ____

____

Relationship: _______________________________________ **Phone No:** ____

Previous GP name & address: ____

Reason for changing GP: ____

____

Pharmacy name & address: ____

____

Please note that completion of this form does **NOT** guarantee acceptance to the Practice. Registration will only be completed following attendance at a registration appointment, receipt of medial notes from your previous GP and the completion of transfer of your Medical Card/Doctor Visit Card to this Practice if you have one.

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Medical history: ____

____

____

____

Surgical history: ____

____

____

Family medical history of note (e.g., diabetes, heart condition, asthma, etc.)

____

____

____

Allergies: ____

Current medications:
If you prefer, you could get a printout from your pharmacy and attach:

1.	**2.**	**3.**
4.	**5.**	**6.**
7.	**8.**	**9.**
10.	**11.**	**12.**

I, ____(print name) have received a copy of the Practice Privacy Statement.

____________________________________ _______________
Signature **Date**

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Data Processing:

Applicants, please note that we reserve the right to refuse treatment and remove patients from the Clinic if:

- They have not disclosed their full medical history in this declaration
- If they mistreat or abuse, either verbally or physically, any staff member

Patient Consent to Data Processing

The information collected on my patient registration form will be held by Church Street medical Centre in electronic format – the manual form having been scanned to file.
The purpose of holding this information is the provision of appropriate healthcare, treatment and services to me as a patient and to ensure my continuity of care and patient safety. I understand that Church Street Medical Centre may also collect information when required by law.
The information will be processed in accordance with Data Protection legislation. Disclosure of this information will only take place with my express consent or in accordance with legislation or regulatory requirements.

Parents/Guardians of patients and patients aged 18 or over have the right to access the personal data held on them by Church Street Medical Centre and to correct it if necessary.

I am aware that I am entitled to:

- Withdraw consent to the processing of my personal information
- Request to access the information Church Street Medical Centre holds about me
- Request the correction of inaccuracies in/erasure of the information Church Street Medical Centre holds about me
- Request the restriction of processing of the information Church Street Medical Centre holds about me
- Exercise my entitlement to data portability
- Make a complaint to the Office of the Data Protection Commissioner of Ireland

I consent to the use of the information supplied as described above.

Signed: _______________________________________ (signature)

_______________________________________ (print name)

Date of Birth: _________________ **Date:** ____________________

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