

Church Street Medical Centre

Moate, Co. Westmeath, N37 H9Y4

Tel.: 090 6481130

E-mail: info@churchstreetmedical.ie

Web: www.churchstreetmedical.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

Medical/Doctor Visit Card No: _____ Expiry Date: _____

Next of kin name and address: _____

Relationship: _____ Phone No: _____

Previous GP name & address: _____

Reason for changing GP: _____

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Pharmacy name & address: _____

Medical history: _____

Surgical history: _____

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

Allergies: _____

Consents: I consent/do not consent to – please tick one:

- | | | | | |
|--|-----|--------------------------|----|--------------------------|
| • Digital sending of prescriptions to pharmacy | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Digital sending of social welfare certs | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Contact via SMS | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • Contact via email | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| • AI Listening | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

I understand and accept that it is my responsibility to contact the Practice with any update in my contact details – such as a change of address, phone number, email address, etc.

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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

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

Check List:

- Have you filled out sections on all pages?
- Have you provided proof of address?
- Have you provided ID?

For each person wishing to become a patient here, a form must be filled out.



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.

I am aware that the practice email is not an appropriate forum for discussing medical issues of any description and that it is not monitored constantly.

I am aware that the Practice uses PIPPO for ordering repeat prescriptions and that if I do not wish to use PIPPO then I must leave in a complete list of required medications. I understand that I cannot email in a request for this.

Signed: _____
Signature

Print name

Date of Birth: _____

Date: _____