Kinvara Clinic
Kinvara West
Kinvara
Co. Galway
Phone: 091-841509

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 records. Our practice is consistent with the Medical Council guidelines and the privacy principles of the Data Protection Acts.

First Name: ______________________________ **Surname:** ___________________________________

Please circle: Male/Female

Date of Birth: / /

Address:____

Mobile Number: _______________________________________

Medical Insurance Company: ______________________ **Policy Number:** ______________________

Medical Card Number: ______________________ **Please circle:** GMS/DVC/Under 8s

Assigned GP on Medical Card: _______________________ **Expiry Date:** / /

PPSN: _________________________

Allergies: ____

Pharmacy: ____

Please give concise answers to the questions below:

- Do you suffer from any medical conditions?

- Have you ever undergone any surgery?

- Were you ever treated in hospital for any condition?

- Are you taking any prescribed medications?

Consent to receive SMS messaging: Yes/No

Consent to hold PPSN on file: Yes/No

Signature: ____________________________________

This form should be emailed to kinvaraclinic@gmail.com.