

New Patient Application Form

In order to provide for your care we need to collect and keep information about you and your health in your medical record. Please complete the following form carefully. The 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 Privacy Statement. ([Attach link](#))

Submitting this form does not guarantee acceptance to the practice. A member of our team will contact you if we have an opening on our list. If you are accepted as a new patient and have a chronic medical condition or take regular medications, we request that you arrange a registration consultation with one of our GPs.

Please note that one form must be completed per applicant. Parents/Guardians may complete a form on behalf of their child.

Full name			
Address			
	Eircode		
Date of birth		Gender	
E-mail Address			
Phone (s)	Mobile:	Home:	
Previous GP and Practice Name			
GP Address			
Next of Kin	Relationship	Phone Number	
Do you have a Medical Card or a Doctor visit card		☐ Yes ☐ No	
If so state card number and expiry date			
Please detail any existing or previous medical conditions or surgical procedures			

Please detail all medications you are currently taking, including over the counter medications/supplements			
Are you allergic to Penicillin?			☐ Yes ☐ No
Are you allergic to any medications?			☐ Yes ☐ No
If yes then please advise which ones:			
Do you drink alcohol?	☐ Yes ☐ No	Do you smoke?	☐ Yes ☐ No
Do you have any other family members who wish to join the practice?			
Family History: Do your siblings, children or parents have any medical conditions? If so please list below.			

The practice may wish to contact you by text message (SMS) regarding appointments, test results and practice updates.

Do you consent to be contacted by text message? *

- ☐ Yes, I consent to being contacted by SMS messages
- ☐ No, I do not consent to being contacted by SMS messages

- ☐ I understand that completing this form does not guarantee acceptance to the practice.
- ☐ I consent to this practice obtaining my medical records from my previous GP if I am accepted to the practice, in accordance with Data Protection Legislation.
- ☐ I have read the practice Privacy Statement

Declaration:

By submitting this form I certify that all information provided in this application form is true, accurate, and complete. I understand that providing incorrect or misleading information—including but not limited to the location of my current medical practice will result in the cancellation of this registration application and I will not be accepted to the waiting list / practice.

Signature: _____ Date: _____