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## Change of Information Form

*Please download and use this form to notify us of any changes to your personal information*

**Please complete using block capital letters**

**Surname:** \_\_\_\_\_ **First Name:** \_\_\_\_\_

**Date of Birth:**        /        /  
(For verification purposes)

*(Only complete the information which should be changed on your patient file)*

**Address:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Tel No:** \_\_\_\_\_ **Mobile:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_

**Marital Status:** \_\_\_\_\_

**Medical Insurance Company:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_

**Medical Card number:** \_\_\_\_\_ **Exp Date:** \_\_\_\_\_

**Next of Kin full name:** \_\_\_\_\_

**Next of Kin D.O.B:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Next of Kin mobile number:** \_\_\_\_\_

We use text and email to give you confirmation of appointments and some test results.  
Please indicate whether you would like to give your consent for us to send you  
information using these methods:

Yes ☐ No: ☐ (please tick one)

*All information is treated in the strictest of confidence*