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The Surgery, Athenry Primary Care Centre

Raheen, Athenry, Co.Galway H65 KH93

New Patient Form

You are welcome to The Surgery, Athenry. Please supply the following information so that we may prepare an individual chart for you

Please complete using block capital letters

Surname: _____ First Name: _____

Male: ☐ Female: ☐ (please tick one)

Date of Birth: / / Occupation: _____

Address: _____

Tel No: _____ Mobile: _____

(If the new patient is a minor, a contact number must still be given with full name of phone owner)

Email: _____

Marital Status: _____

Medical Insurance Company: _____ Policy Number: _____

Next of Kin full name: _____ Relationship: _____

Next of Kin mobile number: _____ Next of Kin D.O.B: _____

Medical Card: Yes ☐ No ☐ Medical Card No: _____

PPS NO: _____

Do you have any allergies: _____ Specify any particular ingredient: _____

Do you smoke? Yes ☐ No ☐ (please tick one) How many per day: _____

Do you drink? Yes ☐ No: ☐ (please tick one) How many per week: _____

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