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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. Please supply the following information so that we may prepare an individual chart for you. Declaration & consent must be signed on page 2.

Complete using block capital letters

Surname: _____ First Name: _____

Male: Female: (please tick one) Date of Birth: / /

Occupation: _____

Address: _____

Postal/Eircode: _____ Email Address: _____

Tel No: _____ Mobile: _____

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

Marital Status: _____

Medical Card: Yes No

Medical Card Number: _____ if applicable

Medical Insurance Company: _____ Policy Number: _____

Do you have any allergies? _____

Specify any ingredient(s) you are allergic to: _____

Do you smoke or used to? Yes: No: (please tick one)

How many per day: _____

Do you drink? Yes: No: (please tick one)

How many per week: _____

Next of Kin full name: _____ Relationship: _____

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

We use Prepare Me. This is a service that assists patients who are anxious about visiting a Doctors Surgery. If you feel you require this service, please tick the box so we can alert your GP/Nurse

pls turn over this page

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Text & Email

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 both these methods:

Yes: No: (please tick one)

Data Protection and Freedom of Information notice

The Surgery will treat all personal information and data you provide as part of this application, as confidential and store it securely.

When The Surgery receives the completed application form, it will make a computer record for the named applicant.

This record will contain the relevant personal information you have supplied.

This personal record will be used and kept by The Surgery, for the purposes of delivering healthcare services to you.

The Surgery will not disclose (share) to other people or organisations the personal information you have given unless consent has been given by the person authorised to give this consent, or if The Surgery is required to do so by law.

(Please note this is optional.)

Signature: _____ Date: ____/____/____

Declaration and Consent

I am applying to be a new patient of The Surgery.

I declare that the information I have given is correct to the best of my knowledge.

I agree that my pharmacist may contact The Surgery regarding prescribed medicines from time to time.

If it applies, I confirm that I am the parent or legal guardian of the named applicant, and I give consent on their behalf.

If you are signing on behalf of the applicant, please add your relationship to applicant below

Your Signature: _____ Block Capitals _____

Relationship to applicant: _____