

# Clady Medical Practice

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## Patient Registration and Medical Summary Form

Today's date: \_\_\_\_\_

Surname: \_\_\_\_\_ First name: \_\_\_\_\_

Known as: \_\_\_\_\_

Title: Mr /Mrs./Ms/ Other \_\_\_\_\_

Date of birth: \_\_\_\_\_ Gender: Male / Female

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

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Mobile: \_\_\_\_\_

I am happy to receive alerts from the practice by  
mobile phone

GMS number: \_\_\_\_\_ Expiry date: \_\_\_\_\_

### Next of kin:

Name: \_\_\_\_\_

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

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

Phone: \_\_\_\_\_

Previous GP name and address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PPSN number:** To avail of certain governmental schemes (e.g. Social welfare certificates, Mother and Child Maternity Scheme, Cervical Check, Childhood vaccinations) it will be necessary for you to provide us with your PPSN number.

**Further information:** The following information is not essential but may be of use to your doctor when they are diagnosing a problem or deciding on a treatment plan for you.

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

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

Ethnic origin: \_\_\_\_\_

Allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical history: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Surgical history: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Current medications:

If you are unsure you could bring your empty pill boxes with you or get a printout from your pharmacist

### Part 3 – Patient Statement

In order to provide for your care we need to collect and keep information about you and your health in your personal medical record. 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 Practice Privacy Statement.

I \_\_\_\_\_ (Print Name) have read and agree to the above policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

