Clanmaurice Medical Practice

Abbeydorney/Ballyheigue, Tralee, Co. Kerry.
Telephone: 066 7135525, 066 7133200,
Email: Reception@clanmauricemp.com

New Patient Registration Form

First Name: _____ Surname: _____ Gender: Male / Female

DOB:___/____/_____ Nationality: _____ PPS no:_____

Address:_____

_____ Eircode:_____

CONTACT DETAILS Home Phone:_____/_____ Mobile:_____/_____

Email: _____

MEDICAL COVER
Medical Card Number: _____ Exp date:_____

Private Medical Cover (please circle): YES / NO If yes, please fill in the following;

Name of Company :_____ Policy Number: _____

ALLERGIES (Please list any that are known to you):_____

_____

MEDICATIONS (Please list all current medications):_____

_____

EMERGENCY CONTACT DETAILS
Name of Contact: _____ Relationship to you:_____

Contact Number:_____

PREVIOUS GP NAME & ADDRESS: _____

_____

PLEASE READ AND SIGN BELOW FOR SMS/EMAIL CONSENT:

I consent to the practice contacting me by SMS text message and/or email for the purpose of health promotion, practice news, and/or appointment reminders.

Text messages are generated using a secure facility, but I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure; however the practice will endeavour not to transmit any information which would enable an individual patient to be identified.

Signature_____ Date_____