The Medical Centre

Whitehall, Galway, H91 D9FW
Telephone: (091) 564241 **Fax:** (091) 566020
Email: whitehallmedicalcentre.gp@healthmail.ie

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: _____ Name: _____

Male: ☐ Female: ☐ Date of Birth: / /

Occupation: _____

Address:

_____

_____

Poste Code: _____ Email Address: _____

Mobile Number: _____

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

Medical Card Number if applicable: _____

Medical Insurance Company: _____ Policy Number: _____

MEDICAL INFORMATION:

Do you have any allergies? _____

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

Do you smoke or used to? _____

If yes how many a day _____

Do you drink? _____

If yes how many a week? _____

Next of kin full name: _____

Relationship: _____

Next of Kin Mobile Number: _____

Data Protection and Freedom of Information Notice

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

When the surgery received 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 Whitehall Medical Centre for the purposes of delivering healthcare services to you.

Declaration and Consent

I am applying to be a new patient of Whitehall Medical Centre.

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

I agree that my pharmacist may contact Whitehall 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: _____