Flower Hill Medical
GP Surgery 046 908 5555

72 B Flower Hill Road, Navan, Co. Meath

PATIENT REGISTRATION FORM

Please complete this form in BLOCK LETTERS.

Patient Information

Title: ☐ Mr ☐ Ms ☐ Mrs ☐ Other _____

First Name _____ **Surname** _____

Date of Birth _____ **Gender** _____

Address _____

_____

Eircode _____

Phone (Home) _____ **Mobile** _____

Email _____ **PPSN** _____

Next of Kin / Emergency Contact

Name _____ **Contact / Mobile** _____

Relationship _____ **Email** _____

Address _____

Medical History

Previous GP Name _____

Previous GP Address _____

Medical Card / GP Visit Card No. _____

Any Allergies _____

_____

Note: If you have a Medical Card or GP Visit Card, you will need to sign a transfer of medical card form.

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DECLARATION AND CONSENT

Declaration

I am applying to be a new patient of Flower Hill Medical. I declare that the information I have given is correct to the best of my knowledge.

I understand that if any information I have provided is found to be false, incomplete or misleading, or if relevant information has been deliberately withheld (including previous GP details, medical history, current medications or medical card status), Flower Hill Medical may decline my application or cancel my registration.

Consent

By registering with Flower Hill Medical, I/we agree and consent to the following:

- Keeping Flower Hill Medical informed of any change to the information given above.
- Aspects of my/our medication or medical history being discussed with a pharmacist or healthcare professional, where appropriate, to facilitate care.
- Flower Hill Medical sharing data (e.g. contact number), when necessary, with hospitals, pharmacies etc.
- Flower Hill Medical contacting me/us by phone, text message and email.
- Registration for the online prescription ordering system, and my/our data being stored and used for that purpose.
- The practice website storing my/our submitted information so the practice can respond to my/our inquiry.

Where applicable: I confirm that I am the parent or legal guardian of the named applicant, and I give consent on their behalf.

Relationship to applicant _____

Signature

Signature _____ **Date** _____

Name (block capitals) _____

Please note: Registration is not complete until you have been notified by the practice. Acceptance to the practice is dependent on availability and on the accuracy of the information provided.

Flower Hill Medical adheres to Medical Council guidelines and the principles of Data Protection legislation in relation to all our patients. Further details are available in our Privacy Policy statement. When the practice receives the completed registration form, it will make a computer record for the named applicant. All medical records are computerised and we adhere to Medical Council and GDPR guidelines in relation to all our patient data.

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RELEASE OF MEDICAL RECORDS

Patient Details

Full Name _____ **Date of Birth** _____

Address _____

_____

Records Requested

☐ Prescriptions ☐ Test results ☐ Medical records

Authorisation

I, _____, hereby request that my medical records be released to Flower Hill Medical with my consent. I request that my medical records be transferred to:

Dr Rajneet Singh
Flower Hill Medical
72 B Flower Hill Road
Navan, Co. Meath
Phone: 046 908 5555

I authorise the release of my medical records as indicated above.

Signature _____ **Date** _____