#### Mount Merrion Medical Clinic Patient Registration Form (Adult)

*Dear patient, data protection regulations changed in 2018. Therefore we want to revise the data we hold on you. Medical records, including this form, will be stored securely and in confidence in accordance with data protection legislation. We ask your cooperation and authorisation by completing this updated registration form. Please return the completed form to the receptionist who can answer your queries.*

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| Title (Ms, Mrs, Mr, Dr, Prof etc.) \_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_PPS Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Maiden Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Post Code \_\_\_\_\_\_\_\_\_\_\_\_\_ IHI Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Male / Female (circle appropriate) Mother’s Maiden Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Nationality \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity (Irish, British, German, Polish, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_Next-of-Kin - Name and Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Phone Numbers: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I will / will not (*circle as appropriate*) accept NORMAL test results and reminders by SMS to the above mobile number until further notice. Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_20\_\_\_ |

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| Every effort is made to protect patient privacy. However, in an emergency, we may need to call someone on your behalf. Please list below the name of someone we have your permission to contact if necessary.Emergency Contact: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Emergency Contact: Telephone No: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Signature (required):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Regarding Telephone Messages: Patient privacy considerations prevent us from leaving medically-related messages on your voicemail / answer system(s) unless you choose to authorise us to do so. Authorising the recording of medically-related messages on your voicemail / answering system(s) is your choice, not your obligation. If you choose to authorise us to leave medically-related messages on your voicemail or answer message system(s), please read and sign the following: “*I hereby authorise Mount Merrion Medical Clinic to leave a message on the answering device at*(\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Telephone number) (Location – “home,” “office,” etc.)**“***I understand that the information contained in the message may concern test results, laboratory studies or general medical information. I further understand that said message may not be secure or private.*” |

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| Marital Status: (Circle your reply) Single, Married, Partner, Widowed, Divorced, Separated, OtherNumber of children \_\_\_\_\_\_\_\_\_ Please list children’s names and dates of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you employed at present YES / NO? What is your occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have you a Medical Card or Doctor’s Visitor Card YES / NO? Card Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have private health insurance YES / NO? Provider (VHI/Aviva/Vivas/Other) \_\_\_\_\_\_\_\_ Policy Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Your health. Please list any operation, disease or long-term illness you suffer from and year of diagnosis:Description \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year of Diagnosis \_\_\_\_\_\_\_\_\_\_Description \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year of Diagnosis \_\_\_\_\_\_\_\_\_\_Description \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year of Diagnosis \_\_\_\_\_\_\_\_\_\_Description \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year of Diagnosis \_\_\_\_\_\_\_\_\_\_Description \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year of Diagnosis \_\_\_\_\_\_\_\_\_\_ |

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| Family History (their state of health, any family conditions, e.g., bleeding disorders, diabetes, breast cancer etc.)Mother \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Brother(s) how many & illnesses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sister(s) how many & illnesses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Do you suffer from any of these (Circle the most appropriate answer)

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| High blood pressure | Yes | No | Don’t Know | Chronic Bronchitis | Yes | No | Don’t Know |
| Diabetes | Yes | No | Don’t Know | Asthma | Yes | No | Don’t Know |
| Heart disease | Yes | No | Don’t Know | Cancer | Yes | No | Don’t Know |
| Depression/anxiety | Yes | No | Don’t Know | Arthritis | Yes | No | Don’t Know |
| Stroke | Yes | No | Don’t Know | Epilepsy/fits | Yes | No | Don’t Know |

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| Please list current medication you are taking | Allergies |
| 1 | Penicillin YES NO |
| 2 | Aspirin YES NO |
| 3 | Foods: |
| 4 | Other specify |

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| **♀** Women | ♂ Men |
| Date of last mammogram \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last cervical smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date last cholesterol test \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last bone density (DEXA) scan \_\_\_\_\_\_\_\_\_ | Date of last PSA \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date last cholesterol test \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of last bone density (DEXA) scan \_\_\_\_\_\_\_\_\_ |

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| Are you (please circle) (1) A smoker (2) Ex-smoker since \_\_\_\_\_\_\_\_ (3) Never a smokerIf a smoker how many do you smoke daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| How many UNITS of the following do you drink weekly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Beer/Stout (1 pint = 2 units) Wine ( 125mls glass=1.5 Unit) Spirits (1 glass = 1 Unit) |

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_20\_\_\_