



Mount Merrion MEDICAL CLINIC

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Registration Form: <16 year olds

Title (Mr/Ms etc.) First name.....Surname.....
Date of Birth...../.../..... PPS Number.....
Address:.....EirCode.....
Gender: Male /Female /Other Birth name (if different).....
Medical Card or Doctor Visit (Under 6) Card Number:.....Expiry:.../.../20...

Primary contact:Relationship.....
Phone: Home.....Mobile.....Consent to receive sms Y/N
Email:.....Consent to receive emails Y/N
Secondary contact:.....Relationship.....
Phone: Home.....Mobile.....Consent to receive sms Y/N
Email:.....Consent to receive emails Y/N
Other : Name:.....Relationship:.....
Telephone No:.....Consent to contact: Y/N
Signed:.....Date:.../.../20...

Previous Doctor/GP:.....
Clinic and address:.....
Phone/Email if known:.....

I(parent/legal guardian) of the child named above consent for the Doctor /Clinic named above to transfer their medical records to Mount Merrion Medical Clinic and also the records of my other dependents listed below

Name:.....Date:.../.../20.....

Dependents: (name and date of birth).....
.....
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Please send the above patients medical records by Healthmail to:

mountmerrionmedicalclinic.gp@healthmail.ie

or by post to:

Mount Merrion Medical Clinic, 71 Deerpark Road, Mount Merrion, Co. Dublin, A94D087

CONFIDENTIAL WHEN COMPLETED

Medical History:

Born: Hospital.....Birthweight.....Delivery (Normal/Caesarean).....

Developmental issues.....

Operations.....

Hospital visits:.....

Immunisations : *(Is your child up to date with Irish Schedule?/ Please attach records if available)*

Allergies:

Medication:

Food/Other:

Medication: Please include inhalers, patches, creams, contraception and medication doses if known

1.)

4.)

2.)

5.)

3.)

6.)

Family History: Please list any medical conditions among your family:

Mother.....Father.....

Brothers.....Sisters.....

Creche/School name and address:.....

Any other relevant information:

Signed: Date:.../.../20...