CONFIDENTIAL WHEN COMPLETED

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 8) 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

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)*

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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…