

Patient Registration and Medical Summary Form

In order to provide your care, we need to collect and keep information about you and your health in your personal medical record. If we accept your registration, your information will be stored on the practice computer. In the event that we are unable to accept your application, we will securely dispose of all information and we will not hold any of your personal data on file.

Part 1 Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Surname:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **First Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known as (if different from above): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender:** Male/ Female: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am happy to receive alerts/texts from the practice by mobile phone:

**GMS Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiry Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Part 2 – HEALTH HISTORY (**must be completed fully)**

Current Medications: (If you are unsure you could bring your empty pill boxes with you or get a printout from your pharmacist).

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Medical Problems:

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Our practices are consistent with the Medical Council Guidelines and the privacy principles of the General Data Protection Regulation.