INCHICORE Medical Centre

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PATIENT REGISTRATION FORM

Please complete in BLOCK LETTERS and return to reception. Items marked * are essential.

PPSN* _____ Surname* _____ First Name*_____

Title_____ Date of Birth_____ Gender* _____

Please note: PPS Number is required to avail of state funded schemes – e.g. Cervical Check, Social Welfare certification certs, childhood immunisations

Address*: _____

_____

Mobile Number* _____ Other Number _____

If you consent to SMS messages (e.g. appointments, test results), check this box ☐

*Do you hold a current medical or doctor visit card?
If yes, please present your card at reception with this form. Yes ☐ No ☐

* Do you wish to have your records transferred from your previous GP? If yes, please complete form B Yes ☐ No ☐

If dependents aged under 16 years to be registered, please list here:

Name:	Date of Birth	Gender	PPSN:
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____

*I confirm that the above information is correct

Signed: _____ Date: _____

Official Use only

Initials of person completing registration: _____ Date _____

Registration information double-check: STC claimed: ☐

Medical Card Valid? GMS / DVC No: _____ Records requested: ☐

COD sent to PCRS ☐ Visitor? ☐