Ballina Medical Centre,
Kevin Barry Street,
Ballina, Co. Mayo.
F26 P6P1

Tel: 096 80600
Email: info@ballinamedicalcentre.ie
Web: www.ballinamedicalcentre.com

Dr Sean Moffatt
Dr Micheal Moffatt
Dr Audrey Rouse
Dr Maura Irwin

New Patient Form

You are welcome to The Surgery. Please supply the following information so that we may prepare an individual chart for you. Declaration & consent must be signed on page 2.

Complete using block capital letters

Surname: ________________________ First Name: ________________________

Male: ☐ Female: ☐ (please tick one) Date of Birth: / /

Occupation: ________________________________

Address: ____

____

Postal/Eircode: _______________ Email Address: ____

Tel No: ______________________________ Mobile: _________________________

(If the new patient is a minor, a contact number must still be given with full name of phone owner)

Marital Status: _________________________

Medical Insurance Company: ________________ Policy Number: _____________

Next of Kin full name: ___________________________________ Relationship: __________________

Next of Kin mobile number: _____________ Next of Kin D.O.B: ___/____/______

Medical Card: Yes ☐ No ☐

Medical Card Number: ______________________ if applicable

Do you have any allergies? _______________________

Specify any ingredient(s) you are allergic to: ______________________________________

Do you smoke or used to? Yes: ☐ No: ☐ (please tick one)

How many per day: __________

Do you drink? Yes: ☐ No: ☐ (please tick one)

How many per week: _________

pls turn over this page

Text & Email

We use text and email to give you confirmation of appointments and some test results. Please indicate whether you would like to give your consent for us to send you information using both these methods:

Yes: ☐ No: ☐ (please tick one)

Data Protection and Freedom of Information notice

The Surgery will treat all personal information and data you provide as part of this application, as confidential and store it securely.

When The Surgery receives the completed application form, it will make a computer record for the named applicant.

This record will contain the relevant personal information you have supplied.

This personal record will be used and kept by The Surgery, for the purposes of delivering healthcare services to you.

The Surgery will not disclose (share) to other people or organisations the personal information you have given unless consent has been given by the person authorised to give this consent, or if The Surgery is required to do so by law.

(Please note this is optional.)

Signature: ___________________________________ Date: ____/_____/_____

Declaration and Consent

I am applying to be a new patient of The Surgery.

I declare that the information I have given is correct to the best of my knowledge.

I agree that my pharmacist may contact The Surgery regarding prescribed medicines from time to time.

If it applies, I confirm that I am the parent or legal guardian of the named applicant, and I give consent on their behalf.

If you are signing on behalf of the applicant, please add your relationship to applicant below

Your Signature: ______________________ Block Capitals________________________

Relationship to applicant: ___________________