

SWORDS ROAD MEDICAL PRACTICE
NEW PATIENT REGISTRATION FORM

Please complete clearly. This confidential information will form part of your medical record.

1. PATIENT DETAILS

Title: _____	First name(s): _____	Surname: _____
Preferred name: _____	Previous surname: _____	Date of birth: ____ / ____ / ____
Address: _____	_____	Eircode: _____
Mobile: _____	Email: _____	Occupation: _____
Sex recorded at birth: _____	Gender / pronouns (optional): _____	PPSN _____

2. REGISTRATION AND CONTACT

☐ Private ☐ Medical Card ☐ GP Visit Card	Card number: _____	Expiry: ____ / ____ / ____
Preferred contact: ☐ Phone ☐ SMS ☐ Email ☐ Post	Primary language: _____	Interpreter / access need: _____

3. PREVIOUS GP AND EMERGENCY CONTACT

Previous GP / practice: _____	Practice address / phone: _____	_____
☐ Please request transfer of my relevant medical records.	Patient initials: _____	Reason for change (optional): _____
Emergency contact: _____	Relationship: _____	Phone: _____

4. CONCISE MEDICAL HISTORY

Tick any condition that applies	Tick any condition that applies	Details / dates
☐ Heart disease / stroke / hypertension	☐ Diabetes / thyroid disorder	_____
☐ Asthma / COPD / lung disorder	☐ Epilepsy / fainting / neurological disorder	_____
☐ Kidney / liver / bowel disorder	☐ Cancer / blood disorder	_____
☐ Arthritis / back / mobility disorder	☐ Anxiety / depression / mental-health disorder	_____
☐ Pregnancy / reproductive-health issue	☐ Other significant illness / disability	_____
Operations, hospital admissions or specialist care (condition, hospital and date):		_____
_____		_____

5. CURRENT MEDICINES AND ALLERGIES

Medicine / strength	Dose / frequency	Reason	Allergy and reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
☐ No regular medicines	☐ No known drug allergies	Preferred pharmacy: _____	

6. COMMUNICATION, PRIVACY AND DECLARATION

Routine permissions: ☐ Discreet voicemail ☐ Appointment/admin SMS ☐ Routine administrative email

I understand that ordinary SMS/email may not be fully secure and must not be used for urgent medical matters. The practice processes personal and health information for direct care, practice administration and its professional and legal duties, as explained in the practice privacy notice.

☐ The information given is accurate and complete to the best of my knowledge.	☐ I have received, read or been offered the practice privacy notice.
Patient name (BLOCK CAPITALS): _____	Signature: _____ Date: ____ / ____ / ____
If completed by parent / guardian: _____	Relationship / authority: _____ Signature: _____

Not for urgent medical problems. If seriously unwell, contact the practice, GP out-of-hours service or 112/999.