Lakeside
Family Practice

ABBREVIATED PATIENT REGISTRATION FORM

For temporary patients/visitors/occupational health patients/
Or to update existing patient details

In order to provide for your care we need to collect and keep information about you and your health in your personal medical record on our computer system. Our practices are consistent with the Medical Council guidelines and the privacy principles of the Data Protection Act. For further details please ask for a copy of our Practice Privacy Statement.

PLEASE PRINT CLEARLY

Surname : _____ **First name :** _____

Title : Mr / Mrs / Ms / Other : _____ **Date of birth :** ____/____/_____ **Gender :** M / F /Unknown

Address : _____

_____**Eir code :** _____

Telephone : Mobile _____
Do you consent to receive texts? Yes / No : PLEASE CIRCLE
(if you consent to receive texts, please notify us if you wish to opt out)
Telephone : Home _____ **Work** _____
Email address : Please print clearly
_____@_____
for verification purposes you will be asked to email reception@lakesidefamilypractice.ie
before receiving emails from the practice.

Please note by giving us this email address it is presumed that you are willing to be contacted by email. Please notify us if you wish to opt out.

PPS Number : _____ **Medical Card No :** _____

Next of Kin : Name _____ **Relationship :** _____

Telephone No : _____

Signature : _____ **Date :** ___/___/____