THE RISE FAMILY PRACTICE

Dr Deirdre McGonagle

REGISTRATION FORM

Family Name _____ **First Name** _____

Date of Birth _____

Address _____

_____

Your Mobile Number: _____

I give my permission for the surgery to contact me by text. Yes ☐ No ☐ (Please note that our text service is used only for matters relating to your healthcare and is not used for promotional purposes)

Next of Kin (Name & Telephone No.) _____

Name & Address of Previous GP _____

_____

PPSN Number: For you to avail of certain government schemes (e.g. Social Welfare Certificates, Mother & Child Maternity Scheme, Childhood Vaccinations, Cervical Check) it will be necessary for us to ask you for your PPSN number. **The Doctor or Receptionist will ask you for your number, if and when it is required.**

Other Family Members who wish to register with this Practice

Family Name: _____ First Name _____ Date of Birth _____

Family Name:_____ First Name_____ Date of Birth _____

Family Name:_____ First Name_____ Date of Birth _____

Family Name:_____ First Name_____ Date of Birth _____

To be completed by GMS Medical Card holders only:

Your Medical Card number _____

Please list the Medical card numbers of your family members if they are also moving to this Practice:

Medical Card Number _____ First Name _____

Medical Card Number _____ First Name _____

Medical Card Number _____ First Name _____

Medical Card Number _____ First Name _____

Signature _____ Date: _____