NEW PATIENT REGISTRATION FORM

CASTLE STREET SURGERY

Surname: _____

Forename(s): _____ **Maiden Name**: _____

Address: _____

_____

_____

Date of birth: ___ / ___ / _____ (Day / Month / Year)

Phone: (**H**) _____ (**W**) _____ **Mobile**: _____

Email: _____ **PPS Number**: _____

Marital status: _____ **Occupation**: _____

Medical Card: Yes / No (If Yes) **Medical Card No**: _____

Private Health Insurance: Yes / No

Health Insurance Provider: _____ **Policy Number**: _____

Next of Kin: _____ (in case of emergency): **Telephone**: _____

By signing below you agree to abide by the Castle Street Surgery Practice Polices (these are available to view on www.cssdoctor.ie)

Patient's Signature: _____

Date: ____ / ____ / _____ (Day / Month / Year)

Please tick as appropriate:

☐ **I do consent** to Castle Street Surgery contacting me by email and/or text message.

☐ **I do not consent** to Castle Street Surgery contacting me by email and/or text message.