PATIENT IDENTIFICATION FORM

ADULT FORM PAGE 1

PLEASE COMPLETE IN BLOCK CAPITALS

PHOTO ID WILL BE REQUIRED TO VERIFY IDENTITY AND A COPY SCANNED TO YOUR CHART

PLEASE ENSURE THAT YOU MAKE US AWARE OF ANY CHANGES TO YOUR PERSONAL OR MEDICAL INFORMATION

YOUR APPLICATION TO JOIN THE PRACTICE WILL BE REVIEWED BY A GP, YOU WILL BE CONTACTED WITHIN 2 WEEKS TO UPDATE YOU

We want to ensure the highest standard of medical care for our patients. A General Practice is a trusted community governed by an ethic of privacy and confidentiality. Our practices are consistent with the Medical Council guidelines and the privacy principles of the Data Protection Acts. In order to provide your care we need to collect and keep information about you and your health on computer records. We retain your information securely. All staff are bound by confidentiality agreements that explicitly makes clear their duties in relation to personal health information.

TITLE		**MR**		**MRS**		**MISS**		**MS**	**OTHER PLEASE SPECIFY**

SURNAME	
FIRST NAME	

DOB DD/MM/YYYY								

GENDER		**MALE**	**FEMALE**

ADDRESS LINE 1	
ADDRESS LINE 2	
ADDRESS LINE 3	
ADDRESS LINE 4	

TELEPHONE NUMBER	**H**		**M**	

EMAIL ADDRESS	

NATIONALITY		**OCCUPATION**	

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PRIVATE HEALTH INSURANCE ☐ **IRISH LIFE** ☐ **VHI** ☐ **LAYA** ☐ **GLO** ☐ **OTHER PLEASE STATE**

OTHER PRIVATE MEDICAL COVER

POLICY NUMBER

ARE ALL MEMBERS OF YOUR FAMILY THAT ARE JOINING LIVINGHEALTH COVERED UNDER THIS POLICY **YES** ☐ **NO** ☐

CURRENT GP NAME & ADDRESS

MEDICAL CARD NUMBER **EXPIRY DATE**

Where you hold a medical or doctor visit you will be registered with a GP in the practice

EU HEALTH CARD NUMBER **EXPIRY DATE**

NEXT OF KIN NAME

NEXT OF KIN RELATIONSHIP

NEXT OF KIN CONTACT DETAILS

How did you hear about us?

Family member is a patient ☐
Recommendation ☐ **GP** ☐ **Other** ☐
Web search ☐
Other ☐

Please give brief details:

BY SIGNING THIS FORM YOU AGREE TO ABIDE BY THE PRACTICE CODE OF CONDUCT, A COPY OF WHICH IS AVAILABLE AT YOUR REQUEST AND TO YOUR AGREEMENT TO ALLOW US TO RETAIN THE PERSONAL INFORMATION PROVIDED IN AND WITH THIS FORM

SIGNATURE **DATE**

For admin use only			
GP reviewed		Date	
Photo ID verified		Date	
Chart opened by		Date	
ID form and photo ID scanned by		Date	