ABBEY MEDICAL CENTRE

Dr Eoin Curtin Dr Edel Twomey Dr Finbar Fitzpatrick
6 Westgate Business Park, Kilrush Road, Ennis, Co. Clare
T: 065-6829975 | F: 065-6824900
E: info@abbeymedicalennis.ie | H: abbeymedicalcentre.gp@healthmail.ie | W: www.abbeymedicalennis.ie

Application Form

Only for Patients relocating to Ennis who do not currently have a GP in Clare. Due to capacity, we are currently unable to accept patients who already have a GP Clare. This is an application form. It does not imply acceptance.

Title: **Mr** **Mrs** **Ms** **Miss**

Name: ____

Address: ____

Date of Birth: ____

Contact Number: ____

Email: ____

PPS Number: ____

Medical Card No: ____

Occupation: ____

Past Medical History: ____

____

____

Medications: ____

____

Relevant Family History: ____

____

____

Allergies: ____

____

Smoking Habits: ____

Alcohol Consumption: ____

Permission to contact you via Phone/Text/Email: **YES** **NO**

Name of Previous GP: ____

Their Address: ____

____

How did you hear about this Practice?

____

Do you have family members already attending this Practice?

____

Is there a GP you wish to see within this Practice?

____

Additional Family Members also looking to join:

____

____

____

____

____

____

____

____

____

____

ABBEY MEDICAL CENTRE

Dr Eoin Curtin **Dr Edel Twomey** **Dr Finbar Fitzpatrick**
6 Westgate Business Park, Kilrush Road, Ennis, Co. Clare
T: 065-6829975 | **F:** 065-6824900
E: info@abbeymedicalennis.ie | **H:** abbeymedicalcentre.gp@healthmail.ie | **W:** www.abbeymedicalennis.ie

Consent to Data Processing

The information collected on my patient registration form will be held by **Abbey Medical Centre** in manual and in electronic format.
The purpose of holding this information is the provision of appropriate healthcare, treatment and services to me as a patient and to ensure my continuity of care and patient safety. I understand that **Abbey Medical Centre** may also collect information when required to by law.
The information will be processed in accordance with Data Protection legislation. Disclosure of this information will only take place with my express consent or in accordance with legislation or regulatory requirements.
Parents/Guardians of patients and patients aged 18 or over have a right to access the personal data held on them by **Abbey Medical Centre** and to correct it if necessary.
I am aware that I am entitled to:

- Withdraw consent to the processing of my personal information
- Request to access the information **Abbey Medical Centre** holds about me
- Request the correction of inaccuracies in / erasure of the information **Abbey Medical Centre** holds about me
- Request the restriction of processing of the information **Abbey Medical Centre** holds about me
- Exercise my entitlement to data portability
- Make a complaint to the Office of the Data Protection Commissioner of Ireland

I consent to the use of the information supplied as described above and in the Data Protection Patient Information Leaflet which I have received.

Signed: ________________________________*(signature)*

________________________________ *(print name)*

Date: ________________________________