TOWN MEDICAL CLINIC

New Patient Intake Form

TOWN MEDICAL CLINIC
Mullingar Healthcare Complex
Austin Friar St. Mullingar, Co. Westmeath
N91 ED2H

Date:

Patient Details

_____ _____ _____
(Name) *(Date of Birth)* *(Medical Card Number)*

_____
(PPS Number)

_____
(Street Address)

_____ _____ _____
(Town/City) *(County)* *(Eir Code)*

_____ _____ _____
(Home Phone) *(Mobile)* *(Work)*

Which is your preferred method of contact?
☐ Home ☐ Mobile ☐ Work

May we leave messages on your preferred number?
☐ Yes, any message ☐ Only appointment information ☐ No message

_____
(Email Address)

Preferred Pharmacy:

_____ _____ _____
(Name) *(Phone)* *(Fax)*

_____
(Street Address)

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Emergency Contact

_____ _____

(Name) *(Relationship to you)*

_____ _____ _____

(Home Phone) *(Mobile)* *(Work)*

Is there any additional non-medical information that you would like us to know? (Additional addresses, additional emergency contacts, etc.)

Social History

Country of Origin: Spoken Languages: Occupation:

Marital Status: Name of Spouse/Partner:

Children (Names and Birthdays):

Medical History

Name of Previous Family Physician:

Allergies:

Do you smoke? Y ☐ N ☐ If yes, how many do you smoke per day?

If no, did you ever previously smoke cigarettes? Y ☐ N ☐ If yes, when did you quit?

How many alcoholic beverages, if any, do you drink per week?

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Pertinent Medical History

Previous Hospitalizations/Surgeries

Family History of Medical Illness

Current Medication

Medication	Dose	Frequency

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