Dr Brian McEllistrem

General Practitioner
MB, BCh, BAO, MICGP,
DCH, DRCOG, LFOM,
MSc (Med. Ed.), FHEA

Mungret Medical Centre

Dr Muireann Clifford

General Practitioner
MB, BCh, BAO, MICGP,
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New Patient Form

Version 4.0. Further details about Mungret Medical Centre are available on our website mungretmedicalcentre.ie .

Please complete all sections with separate form(s) for each new patient. If a section is not applicable please enter "Nil".

Name	*First Name:*	
	Surname:	
	Alias (e.g. Peg for Margaret) If applicable:	
Date of Birth	*DD/MM/YYYY:*	
Home Address *Address Line 1* *Address Line 2* *Address Line 3* *Address Line 4*		
Home Eircode *Find your Eircode here - eircode.ie*		
Mobile Phone Number (or of parent/guardian)		
Home Phone Number		
Email Address		
PPS Number		
Gender		
Health Insurance Provider & Policy Number *If available*		
Medical Card Number[1] *(GMS, DVC, U8, Over 70 etc.)* *If available*		
Next of Kin and patient relationship to that person		
Next of Kin Mobile Number		
Carer *If applicable*		
Carer Mobile Number *If applicable*		
How Did You Hear About Us?		
Do you have an immediate household family member who is already a patient of MMC, OR who is joining at the same time as yourself?[2]	☐ No	☐ Yes:
		Your relationship to that person:
		First Name:
		Surname:

[1] Fee for first consultation for patients joining MMC, with a valid medical card at time of the consultation, is waived.

[2] This refers to your nuclear family, a family group consisting of parents and their children (one or more), living in one home residence.

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Past Medical History *Please use additional forms if needed*	*e.g Asthma since 2018; mild occasionally salbutamol use*
Past Surgical History *Please use additional forms if needed*	*e.g Appendectomy (keyhole). UHL. 2007*
Significant Family History of Medical Issues	*e.g. Father developed diabetes in his 70s, Mother had high blood pressure since her 50s.*

Pharmacy *It is recommended to choose a single regular pharmacy*	*Name:*		
	Address:	*Eircode:*	

Current Medications (Name and how often taken) *Please use additional forms if needed*	*Medication*	*Dose*	*Frequency*	*Regular/Occasional*
	eg Bisoprolol *eg Ibuprofen Gel*	*2.5mg* *5%*	*Once a day* *Up to four times a day*	*Everyday* *3 or 4 days a month*

Allergies *If applicable* *Please use additional forms if needed*	*Name of medication:*	
	Nature of what happened or reaction:	
Occupation		
Smoker *(Please tick/complete)*	☐ Never ☐ Ex-smoker ☐ Smoker of cigarettes per day;	
Alcohol *(Please tick/complete)*	☐ Non-drinker ☐ Drinker of units per week[3];	
Childhood Vaccinations up to date?	☐ Yes ☐ No ☐ Not Applicable ☐ Other;	
National Screening Service Registered[4] (e.g. CervicalCheck etc)?	☐ Yes ☐ No ☐ Not Applicable ☐ Other;	
Are you currently seeking an appointment?[5]	☐ No	☐ Yes (Reason(s) for Appointment);

[3] Standard glass of wine (195ml) - 2.1 units. Pint of low strength beer - 2 units. Pint of high strength beer - 3 units. Bottle of lager - 1.7 units.

[4] Available here: https://www.screeningservice.ie/ Accessed 26th November 2021.

[5] Further information on requesting appointments is available on our website. Available here: https://www.mungretmedicalcentre.ie/request-appointment. Accessed 22nd October 2026.

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Name of Existing GP	
Address of Existing GP	
Signature (patient/parent/legal guardian as appropriate) *indicating you have read and understood the above, the above is correct to the best of your knowledge, give permission for your previous GP to transfer your medical records to MMC, will update MMC to any changes in the above, and consent to the practice's data policy[6].*	
Name in CAPITALS	
Date of Signature	*DD/MM/YYYY:*

[6] Available here https://www.mungretmedicalcentre.ie/policy/medical-data-policy .