**KERRY SKIN CLINIC (www.kerryskinclinic.ie)**

**NEW PATIENT REGISTRATION FORM (VIDEO CONSULT)**

***Confidential Please print clearly***

1. **NAME : DATE OF BIRTH:**
2. **MALE/FEMALE:**
3. **ADDRESS:**
4. **Occupation: Email address:**

**\*I consent to being contacted by mobile phone, text or email with results,appointments etc 🞎**

 **(please tick box)**

1. **Tel: Mobile:**
2. **Referring person’s name:**
3. **Pharmacy Details: Name, “Healthmail” address and/or phone number:**
4. **Marital status: Married 🞎 Single🞎 Separated🞎 Co-habiting🞎 Widowed🞎 Divorced🞎**

**(Please tick appropriate box)**

1. **Do you have children: a. If yes, how many? b. How many living with you?**
2. **Do you have:**
3. **Health Insurance: YES🞎 if yes please specify below NO🞎**

**VHI🞎, LAYA🞎, IRISH LIFE🞎, GARDA🞎, ESB🞎, OTHER🞎**

**(Please tick correct company above) Policy no: Plan:**

1. **Medical card? YES🞎 NO🞎 Medical Card No.:**
2. **PAST MEDICAL HISTORY: (Specify)**
3. **PAST SURGICALHISTORY: (Specify)**
4. **FAMILY HISTORY OF ANY ILLNESS OR SKIN PROBLEMS:**

**Do any of your first degree relatives (e.g. parents, sisters, brothers or children, living or dead, have/had any of the following? Eczema, psoriasis, skin cancer, diabetes.**

1. **Do you smoke? If yes, how many per day? If an ex-smoker, when did you stop?**
2. **Do you take alcohol? If yes, how many units per week?**

**(1 pint = 2 units, 1 glass wine/spirits = 1 unit)**

1. **Have you any drug allergies? If yes, please list:**
2. **Are you on any medication? (Creams, tablets, inhalers, injections)-please list:**
3. **WOMAN ONLY: First day of your period:**

**Please add more information below if needed:**

***Email or post back to*** ***reception@asctralee.com*** ***Confidentiality is assured at all times***