



HERMITAGE MEDICAL CLINIC

Arrival Time: _____

PLEASE COMPLETE ALL FIELDS IN BLOCK CAPITAL LETTERS

FULL NAME (i.e.: Patrick not Pat) _____

DATE OF BIRTH: _____

ADDRESS: _____

PHONE: HOME: _____ MOBILE: _____

HAVE YOU EVER BEEN TO ANY DEPARTMENT IN THE HERMITAGE MEDICAL CLINIC BEFORE? YES / NO

**** NOTE ** ALL PATIENTS ARE LIABLE FOR
ALL EMERGENCY DEPARTMENT FEES ON THE DAY
REGARDLESS OF INSURANCE PROVIDER**

PLEASE SEE EMERGENCY DEPARTMENT PRICE LIST

NEXT OF KIN:

FULL NAME: _____ RELATIONSHIP: _____

ADDRESS _____

PHONE: HOME: _____ MOBILE: _____

YOUR GP/DOCTORS CONTACT DETAILS:

NAME: _____

ADDRESS: _____

BRIEF DESCRIPTION OF COMPLAINT: _____

FOR INPATIENT ADMISSION PURPOSES WE REQUIRE THE FOLLOWING INFORMATION

(Some Insurance Companies Will Have Shortfall / Excess Fees That Will Need To Be Paid Upon Admission)

DO YOU HAVE HEALTH INSURANCE? _____ Y/N

DETAILS:

PLEASE CIRCLE YOUR INSURANCE COMPANY: NONE / VHI / QUINN / HIBERNIAN / GARDA / ESB / POMAS

PLAN TYPE: _____ POLICY NUMBER: _____

(E.G: VHI B options , Quinn Essential plus, Hibernian I Plan 2)

PATIENT / REPRESENTATIVE SIGNATURE: _____