108 MEDICAL CHAMBERS – REGISTRATION FORM

PATIENT DETAILS		
TITLE:	FORENAME(S):	SURNAME:
DATE OF BIRTH:		
UK ADDRESS:		
OVERSEAS ADDRESS:		
TELEPHONE:	MOBILE:	
EMAIL:		
NEXT OF KIN:	PHONE NO:	
WHO REFERRED YOU TO 108 HARLEY STREET:		

GP/SPECIALIST DETAILS	
GP NAME: Dr	SPECIALIST NAME:
GP ADDRESS:	SPECIALIST ADDRESS:

PAYMENT DETAILS	
PAYMENT TYPE: **SELF FUNDING / INSURANCE / EMBASSY / OTHER – (please complete below as appropriate)**	
INSURANCE COMPANY:	MEMBERSHIP NO:
	AUTHORISATION CODE:
	POLICY EXPIRY DATE:
EMBASSY: TRANSLATOR NAME:	LETTER OF GUARANTEE: Contact Person: Telephone number: Email:

Appointment confirmation email and link to 108 fees received **YES** ☐ **NO** ☐

Proof of address **YES** ☐ **NO** ☐
What document was provided? ……

Would you like a chaperone to sit in your appointment **YES** ☐ **NO** ☐

Please List Allergies ……..

Annual review reminder **YES** ☐ **NO** ☐

Do you consent for us to send your GP/Consultant/Insurance Company a copy of your clinic letter/report **YES** ☐ **NO** ☐

We strongly recommend you tick YES so we can provide you and your medical team with the best of care. To tick NO may compromise your care and cause implications if we cannot communicate with your medical team. It is important for your Consultant/GP to receive all copies of your letters and reports

Would you like a copy of your clinic letter **YES** ☐ **NO** ☐

Would you like us to retain your medical notes **YES** ☐ **NO** ☐

Do you consent for us to add your patient questionnaire feedback on our website? **YES** ☐ **NO** ☐

If required, do you consent in the future for your images to be sent to other medical organisations? **YES** ☐ **NO** ☐

Signature: …… Date …….