# 108 MEDICAL CHAMBERS – REGISTRATION FORM

| PATIENT DETAILS | | |
|---|---|---|
| TITLE: | FORENAME(S): | SURNAME: |
| DATE OF BIRTH: | | |
| U.K. ADDRESS: | | OVERSEAS ADDRESS: |
| TELEPHONE: | | MOBILE: |
| EMAIL: | | |
| NEXT OF KIN: | PHONE NO: | |
| HOW DID YOU HEAR OF 108 HARLEY STREET: | | |

| GP/SPECIALIST DETAILS | |
|---|---|
| GP NAME: | 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:<br><br>TRANSLATOR NAME: | LETTER OF GUARANTEE:<br>Contact Person:<br>Telephone number:<br>Email address: |

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

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

Chaperone required **YES** ☐ **NO** ☐

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** ☐

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 …….