108 MEDICAL CHAMBERS – REGISTRATION FORM

PATIENT DETAILS		
TITLE:	FORENAME(S):	SURNAME:
DATE OF BIRTH:		
ADDRESS:		
TELEPHONE:	MOBILE:	
EMAIL:		
NEXT OF KIN:	PHONE NO:	

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

PAYMENT DETAILS	
PAYMENT TYPE: **SELF FUNDING / INSURANCE / EMBASSY / OTHER – (please complete below as appropriate)**	
INSURANCE COMPANY:	MEMBERSHIP NO:
	AUTHORISATION CODE:
EMBASSY:	LETTER OF GUARANTEE: Contact person : Telephone number : Email:
TRANSLATER	Name: Company: Telephone number : Email:

I confirm that above details are correct.

Please tick as appropriate:

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

Chaperone required **YES** ☐ **NO** ☐

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

Do you consent for us to send your GP/Consultant 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

Do you consent for us to share your clinic letter/report with your Insurance Company if required **YES** ☐ **NO** ☐

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

Signature: …… Date ……