REGISTRATION FORM

PERSONAL DETAILS Title ....

Full Name...

Date of Birth .... Gender .... Nationality ....

Home Address ....

Telephone
(Home) ……………………………………………
(Business)...
(Mobile) ....

E-mail ....

Next of Kin .... Relationship ....

Tel. No. ....

GP Name ....

GP Tel ....

GP Address
....
....

Ethnicity (optional) ....

Occupation ....

Marital Status..................

Dentist None........ Private......... NHS........ (please tick)

....

Medical Insurer ....

Policy Number ....

CONTRACT

H&B Medical undertakes to provide to you, as their registered patient, private primary medical care of the highest possible quality. They regard duty of care to you as a relationship of the utmost importance and believe that mutual openness and honesty are vital to the satisfactory care of your health. H&B medical will be available in their rooms by appointment. Home visits and out-of-hours cover cannot normally be provided. You are advised to maintain registration with your NHS general practitioner and, with your consent, he or she will be kept fully informed. All usual medical facilities and services will be provided, including a wide range of diagnostic tests and, where appropriate, referral for specialist advice. Your details will be held in the strictest confidence and the terms of the Data Protection Act 1998 strictly observed. Fees will be charged for services rendered in accordance with the scale published on the website, which may be amended from time to time and without notice. Accounts must be settled before leaving the surgery. Telephone and email consultations will be charged at the normal rate. Late cancellation and non-attendance of booked appointments will incur fees up to the normal fee for the booked appointment time, in accordance with the published scale. In your absence an account statement will be sent to you on and should be paid within 30 days. I agree to the above terms and conditions.

Signature ....

Date .... (parent / guardian of patient aged under 18)

INFORMING YOUR NHS GP

It is good practice for your NHS GP to be kept informed of any developments related to your health. Please sign here if you wish H&B Medical to send your NHS GP a summary of your consultations with him, including any abnormalities or significant results which may require further investigation or treatment.

Signature .... Date...

DEBIT / CREDIT CARD AUTHORITY

Accounts must be settled before leaving the surgery.

CHAPERONING

If you prefer a chaperone to be present during your consultation or examination, arrangements will need to be made to have a suitably qualified chaperone attend during your appointment. Notice will be required when making your appointment and a fee of £30.00 may be incurred on each occasion. I will / will not / may sometimes (delete as applicable) require a chaperone to attend during my appointment.

Signature ....

Date ....

PREFERENCES

Preferred Calling Name ……………………………………………….

How would you prefer us to contact you with test results and surgery updates?

We will not generally leave answerphone messages.

Post / Email / Text / Home telephone / Mobile

H&B Medical

YOUR MEDICAL HISTORY

LIFESTYLE

Smoking: Do you smoke? Never / Given up / Yes Details ....

Alcohol: How many units per week? .... units

(small glass wine 1 unit, large 3; pint of standard beer/ale 3 units)

MEDICAL HISTORY

Have you had any of the following? Please tick and give details and dates:

Heart disease, chest pain, palpitations, high blood pressure, vascular disease.

Asthma, bronchitis, pneumonia or other lung disease.

Persistent indigestion, ulcer, colitis, hepatitis or other disease of the liver, pancreas or bowel.

Recurrent urine infection, stones, kidney or bladder disease.

Arthritis, rheumatic disease, gout, back pain, spinal , bone, joint or muscle disease.

Fits, blackouts, epilepsy, paralysis, stroke or other nervous system disease.

Depression, anxiety, mental breakdown or psychiatric problem.

Diabetes, thyroid or other glandular disorder.

Anaemia or blood disorder.

Ears, nose and throat problems.

Glaucoma, eye problems.

Sexually transmitted infection, HIV / AIDS. Tropical disease, malaria etc. Blood transfusion.

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Skin problems, eg eczema, psoriasis.

Sterilisation or vasectomy.

Disease of ovary, cervix or uterus.

Any other condition, surgical operation, tumour or serious injury.

TESTS and INVESTIGATIONS

Have you had any of the following tests?

Please provide details of where and when:

X-ray, mammography, CT or MRI scans, ultrasound ECG, echocardiogram, angiogram Endoscopy, colonoscopy Other specialist investigation

FAMILY HISTORY

Age(s) if alive Age at death State of health / cause of death Father Mother Brothers Sisters Sons Daughters

Do you have any family history of:

Diabetes Aortic aneurysm Heart attack High blood pressure Angina or bypass Glaucoma Bowel cancer Prostate cancer Breast cancer Osteoporosis Ovarian cancer Stroke

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HOSPITAL ADMISSIONS

Please give details of any hospital admissions in the last three years:

MEDICATION

Please list any medicines or supplements you are taking, either prescribed or bought over the counter:

ALLERGIES

Please list any allergies, including allergies to medicines :