



REGISTRATION FORM

All information is held in the strictest confidence but will be shared with any **Consultants** should you require referral to a specialist.



YOUR DETAILS

SURNAME:

FIRST NAME:

TITLE: DATE OF BIRTH: NATIONALITY: SEX: MALE FEMALE

CURRENT ADDRESS:

..... POSTCODE

TEL NO: (HOME/WORK) (MOBILE)

EMERGENCY CONTACT / PARENT OR GUARDIAN

NAME: RELATIONSHIP:

ADDRESS:

TEL NO: (HOME / WORK) (MOBILE)

GP DETAILS / HEALTH VISITOR (UNDER 5 YEARS OLD) OR SCHOOL (OVER 5 YEARS OLD)

GP NAME:

ADDRESS:

.....

PLEASE TICK IF YOU **DO NOT** WANT US TO CONTACT YOUR GP

HEALTH VISITOR OR SCHOOL:

HOW ARE YOU PAYING?

CASH CREDIT/DEBIT CARD CORPORATE ACCOUNT

Join Medicard today and **save up to 45% off** standard rates – ask at reception for more details

ADDITIONAL INFORMATION

Where did you hear about us? Would you like to receive special offers by email? YES NO

EMAIL:

From time to time we may wish to advise you of both Casualty Plus / Medicentres (UK) Ltd and our selected partners, products and developments. We will not release your name and address to any third party (including any Casualty Plus / Medicentres (UK) Ltd partners) under any circumstances. If you do not wish to receive any correspondence from us at any time, please tick box.

PLEASE COMPLETE THE BRIEF MEDICAL QUESTIONNAIRE OVERLEAF

Reason for seeing Doctor/Nurse

Prefer not to say

Please tick the appropriate circle when answering the questions. Where you have answered YES please give details.

	No	Yes	Details
Are you a smoker?	<input type="radio"/>	<input type="radio"/>	If yes how many?
Do you drink alcohol?	<input type="radio"/>	<input type="radio"/>
Do you/Does your child have any allergies?	<input type="radio"/>	<input type="radio"/>
Do you/Does your child suffer from any chronic illness or medical complaint other than your present illness?	<input type="radio"/>	<input type="radio"/>
Have you/has your child ever had heart or chest problems?	<input type="radio"/>	<input type="radio"/>
Have you/has your child ever had fits/faints or blackouts?	<input type="radio"/>	<input type="radio"/>
Have you/has your child ever had raised blood pressure?	<input type="radio"/>	<input type="radio"/>
Is this visit related to an injury sustained in an accident of any kind?	<input type="radio"/>	<input type="radio"/>
Do you/Does your child take any medicines (including the contraceptive pill)?	<input type="radio"/>	<input type="radio"/>
Have you/has your child ever had an operation?	<input type="radio"/>	<input type="radio"/>
Have you/has your child ever had problems with anaesthesia?	<input type="radio"/>	<input type="radio"/>
Have you/has your child ever suffered from mental illness?	<input type="radio"/>	<input type="radio"/>
Have you/has your child visited your GP in the last 6 months?	<input type="radio"/>	<input type="radio"/>
Have you/has your child been a hospital in-patient or out-patient in the last 3 years?	<input type="radio"/>	<input type="radio"/>
Are you/your child registered disabled?	<input type="radio"/>	<input type="radio"/>
Is there any other condition which you think the doctor should know about?	<input type="radio"/>	<input type="radio"/>

FEMALE CLIENTS ONLY (IF APPLICABLE/OLDER CHILDREN)

Have you ever had breast problems?	<input type="radio"/>	<input type="radio"/>
Have you ever had irregular periods?	<input type="radio"/>	<input type="radio"/>
Date of last monthly period?		
Could you be pregnant?	<input type="radio"/>	<input type="radio"/>
Have you ever had any children?	<input type="radio"/>	<input type="radio"/>

I have read and understood this health questionnaire. The above information is correct to the best of my knowledge.

I understand that this is a **private medical facility** and I will be charged a consultation fee and that any further treatment or investigations will incur additional charges, as outlined in the current price list. If I am unsure about the total cost of my treatment or investigation, I will seek clarification from staff in advance. **If I am a self pay patient, I will settle my bill in full prior to leaving the facility.**

I understand that there is no obligation to proceed with treatment or investigation after the initial consultation and all prescriptions are non-returnable after leaving the premises.

Print Full Name:

Relationship (if applicable):

Signed: Date:.....