PATIENT REGISTRATION DETAILS

Title Mr/Mrs/Ms/Miss/Other______ **Surname**____________________ **First name**_______________

Date of Birth_________________ **Age**________ **Male/Female** **Occupation**_______________

UK Address __________________________________**Home Tel No.**________________________
____**Work Tel No.**________________________
_________________________**Post code**____________**Mobile No.** _________________________
____**Email**________________________________

Name and Tel No. of Next of Kin____

GENERAL PRACTITIONER (GP):

Name____ **Tel No.**______________________
Address____
____ **Post code**____________________

If you DO NOT wish us to send correspondence to you GP, please sign below:
I do not wish any communication to be sent to my GP, and I accept responsibility for your treatment without GP support.

Signature__________________________________ **Date**___________________
Please note, for some treatments, it is essential that we communicate with your GP. If you have signed above, we will discuss this with you during your consultation.

How did you find out about The London Clinic of Dermatology? Or Name of referring Doctor:
____

Do you have a referral letter from your doctor? Yes ☐ **No** ☐

METHOD OF PAYMENT (Please circle)

Cash **Cheque** **Credit Card** **Other**_________________

PLEASE BE ADVISED THAT IT IS A REQUIREMENT OF THIS CLINIC THAT ALL OUT-PATIENT ACCOUNTS ARE SETTLED ON THE DAY THE SERVICE IS RECEIVED.

Signature____ **Date** _____________________________

OFFICE USE ONLY
Emergency appointment Y / N