SOMDOC WALK-IN CLINIC PATIENT REGISTRATION FORM

Private Walk-in Clinic
Same Day Doctor Appointment

First Name(s):

Surname Name:

Date of Birth: **Gender: M F**

Permanent Address:

Postcode:

Email:

Telephone No:

If Child, full names of Parents or Guardian of Child (please state relationship e.g. Mother, Step-

Name: **Telephone No:**

Relationship:

Please provide details of the person we should contact in case of an emergency

Name: **Relationship:**

Address:

Mobile Number:

NHS GP Details:

(If provided, the relevant info will be shared with your GP, I give permission for you to send my records to my GP)

Yes: **No:**

If Yes
GP Name:

Address:

Do you have medical conditions or allergies? **Yes:** **No:**

If Yes
(Please state)

Would you like us to contact you with any news or information which may be of interest to you? Yes No

I have carefully read and understood this questionnaire and filled out this form to the best of my knowledge. I am aware that this is a private clinic, and I will be charged a consultation fee, and any additional treatments or tests will incur further charges, which I will be made aware of before undertaking. If I am unsure about the costs of my treatments, I will ask for clarification from a member of staff. I will pay the fees I have incurred prior to leaving the clinic. You agree to pay the consultation fee before you see the doctor. I understand there is no obligation to any treatment or tests after the initial consultation. In accepting a consultation with a medical doctor, I agree to pay for that practitioner's time regardless of the outcome of the consultation or any medical form completed by the doctor. If my personal details change in the future, I will notify you as soon as possible.

Signature: ..... **Name:** .....

Parent or guardian if patient under 18: Signature: ..... **Name:** .....

Date: .....