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| **PATIENT REGISTRATION DETAILS** |
| **NAME** | Mr/ Mrs/Miss/Dr/Rank |
| **ADDRESS** | Home / Boarding School / Army |
| **Date of Birth** |  | Service Number (MOD) |
| **Telephone Numbers** | Home | Work | Mobile |
| **E Mail** |  |
| **G.P. Name & Address** |  |
| **Referred By** |  | Has Letter Been Sent |
| **PAYMENT FOR TREATMENT** |
| *PLEASE ENSURE ACCURATE DETAILS OF INSURERS ARE PROVIDED**ALL ACCOUNTS WILL BE SENT DIRECT TO YOUR INSURANCE COMPANY UNLESS OTHERWISE REQUESTED**PLEASE NOTE THAT YOU THE PATIENT OR NOMINATED GUARDIAN IS ULTIMATELY RESPONSIBLE FOR ENSURING PAYMENT OF ALL ACCOUNTS****NON INSURED ITEMS & POLICY EXCESS*** *NON RECOVERABLE EXPENCES* *e.g. ORTHOTICS/ANKLE BRACES & OTHER SURGICAL APPLIANCES ARE DUE DIRECT FROM PATIENT IN ADVANCE OR AT TIME OF ISSUE.* | **Self Funding**Do you wish to pay by Cheque / Card / Cash |
| **Medical Insurance**Company Name:Policy Number: Authorisation Number: |
| **Third Party**Who will settle your account |
| **Treatment of Children**Name and address of Parent / Guardian responsible for Accounts and Medical Correspondence |
| **I AGREE WITH TERMS AND CONDITIONS OF TREATMENT FUNDING**SIGNEDPRINT NAME DATE |