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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**  SIGNED  PRINT NAME DATE | | |