Patient Registration Form

Title:	Forename:	Surname:	Hospital Use Only:
Address:	DoB:	Sex:	MPI No:
	Marital Status:		Room No:
	Nationality:		TCI Date:
	Religion:		Discharge Date:
Post code:	Patients under 16 years of age, please provide details of your school:		
Tel. No:			
Specialist/Consultant:		Procedure:	
GP Name:	GP Address:		

Please indicate how you wish to settle your account. This will include any items not covered by your insurer.

Cash ☐	Cheque ☐	Credit/Debit Card ☐

Credit/Debit Card No. ..... Valid From ..... Exp Date .....

Issue Date (switch).....Please sign below if you wish charges to be deducted from your card.

Signature .....

Transactions of up to £500 will be charged without further reference to you.

OR if covered by Medical Insurance, please complete below:

Medical Insurer's name:	Date Symptoms first noticed by Patient:
Membership's number:	Date first consulted GP:
Policyholder's name	Reason for GP visit/initial symptom:
Scale of cover:	
Scheme/Plan name:	Have you attended this hospital previously?
Employer:	*In-patient* Yes ☐ No ☐
	Out-patient Yes ☐ No ☐
Did the patient receive treatment as the result of an accident caused by someone else? Yes ☐ No ☐	Is the patient covered by any other Insurance from which the cost of treatment might be claimed? Yes ☐ No ☐

If "Yes" to any of the above, please complete the Accidents/Other Insurers section overleaf

Next of Kin Name:	Next of Kin Address:
Relationship:	Tel. (Home): Tel. (Work):

ALL PATIENTS: I hereby undertake to pay Ramsay Healthcare for services and materials relating to my treatment as a private patient including in the circumstances where medical insurance proves not to cover the specific course of treatment. Please be aware that pre-op tests will be invoiced to your insurance company as Outpatient charges.

Data Protection Act: I have been notified of the Data Protection Act as it relates to my data processed by Ramsay Healthcare (see overleaf).

Insured Patients Only: I DECLARE THAT my/the patient's general practitioner recommended the specialist treatment and that to the best of my knowledge and belief the information given on this form is true and complete. I authorise the hospital to submit claims relating to my/the patient's treatment to my/the patient's insurer on my/the patient's behalf.

All patients please sign below:

Signature of Patient	Signature of parent/guardian if patient is under 18:	Date

☐ *Please tick this box if you do not wish to receive other information about Ramsay Healthcare UK services*