Dr Georges S Kaye
Physician

REGISTRATION FORM

PLEASE PRINT DETAILS IN BLOCK CAPITALS

Title: _____ **Date:** _____

Surname: _____ **Forename:** _____

Date of Birth: _____

Address: _____

_____ **Post Code:** _____

Tel Home: _____ **Work:** _____

Mobile: _____ **Email:** _____

Contact details of NHS GP:

Name: _____

Address: _____

_____ **Post Code:** _____

Next of Kin: _____ **Tel No:** _____

Address: _____

_____ **Tel No:** _____

Do you require a chaperone during your consultation? Yes ☐ No ☐

I do not consent to any of my past/current/future medical records or information about myself be communicated, or made available to third-parties without my formal and written permission.

By signing this form, you are giving consent to care and treatment given by Dr Georges Kaye.

Signature: _____ **Date:** _____

Payment

Patients are required to make payments on the day of their consultation. Occasionally, when the provider determines the cost of a special test, an invoice will be forwarded at a later date.