Dr Christopher J Corbin MRCS LRCP MRAeS

The Sanctuary, 5 Priory Gardens, Isleham, Ely, Cambridgeshire.

REGISTRATION FORM

Please complete in BLOCK CAPITALS throughout:

PERSONAL DETAILS

Title ..... Full Name .....

Date of Birth ..... Gender ..... Nationality .....

Home Address ..... Ethnicity .....

..... Occupation .....

..... Marital Status .....

Postcode ..... Dentist None..... Private..... NHS..... (please tick)

Tel (Home) ..... (Business) .....

E-mail ..... (Mobile) .....

Next of Kin ..... Relationship ..... Tel. No. .....

GP Name ..... GP Tel .....

GP Address .....

NHS No. (10 digits) ....

Medical Insurer ..... Policy Number .....

CONTRACT

Dr Corbin undertakes to provide to you, as his registered patient, private primary medical care of the highest possible quality. He regards his duty of care to you as a relationship of the utmost importance and believes that mutual openness and honesty are vital to the satisfactory care of your health. He will be available in his rooms by appointment, generally between the hours of 9.00 am and 6.00 pm on weekdays, though earlier, later and weekend appointments may be arranged at his discretion. Home visits and out-of-hours cover cannot normally be provided. You are advised to maintain registration with your NHS general practitioner and, with your consent, he or she will be kept fully informed. All usual medical facilities and services will be provided, including a wide range of diagnostic tests and, where appropriate, referral for specialist advice. Your details will be held in the strictest confidence and the terms of the Data Protection Act 1998 strictly observed.

Fees will be charged for services rendered in accordance with the scale published on the website, which may be amended from time to time and without notice. Accounts must be settled before leaving the surgery. Telephone and email consultations will be charged at the normal rate. Late cancellation and non-attendance of booked appointments will incur fees up to the normal fee for the booked appointment time, in accordance with the published scale. Your continuous credit card authority will be required to facilitate charging for fees incurred in your absence. An account statement will be sent to you on any such occasion.

I agree to the above terms and conditions.

Signature ..... Date .....
(parent / guardian of patient aged under 18)

INFORMING YOUR NHS GP

It is good practice for your NHS GP to be kept informed of any developments related to your health. Please sign here if you wish Dr Corbin to send your NHS GP a summary of your consultations with him, including any abnormalities or significant results which may require further investigation or treatment.

Signature ..... Date .....

DEBIT / CREDIT CARD AUTHORITY

Accounts must be settled before leaving the surgery and will normally be debited from your card account in your presence and before you leave the surgery. In order that we may debit your account for fees incurred in your absence, we need to hold your card details. You will be made aware of any situation in which you might incur such fees. Your card details will be held securely in accordance with the provisions of the Data Protection Act 1998.

Card Provider ..... Visa / Mastercard / Maestro / Electron/Solo

Card Number ..... CVV *(last 3 nos)* .....

Name as on the card .....

Start Date *(if shown)* ..... / ..... Exp Date ..... / ..... Issue No *(if shown)* .....

I hereby authorise Dr C J Corbin to debit my account *in accordance with my contract with him*.

Signature ..... Date .....

CHAPERONING

If you prefer a chaperone to be present when Dr Corbin examines you, arrangements will need to be made to have a suitably qualified chaperone attend during your appointment. Notice will be required when making your appointment and a fee of £30.00 will be incurred on each occasion.

I will / will not / may sometimes (delete as applicable) require a chaperone to attend during my appointment.

Signature ..... Date .....

PREFERENCES

Preferred Calling Name .....

How would you prefer us to contact you with test results and surgery updates? We will not generally leave ansaphone messages. *Please circle all those applicable below*:

Post Email Text Home telephone Mobile

YOUR MEDICAL HISTORY

LIFESTYLE

Smoking: Do you smoke? Never / Given up / Yes Details .....

Alcohol: How many units per week? ..... units

MEDICAL HISTORY

Have you had any of the following? ***Please give details and dates:***

	Tick	Details	Date(s)
Heart disease, chest pain, palpitations, high blood pressure, vascular disease.			
Asthma, bronchitis, pneumonia or other lung disease.			
Persistent indigestion, ulcer, colitis, hepatitis or other disease of the liver, pancreas or bowel.			
Recurrent infection, stones, kidney or bladder disease.			
Arthritis, rheumatic disease, gout, back pain, spinal , bone, joint or muscle disease.			
Fits, blackouts, epilepsy, paralysis, stroke or other nervous system disease.			
Depression, anxiety, mental breakdown or psychiatric problem.			
Diabetes, thyroid or other glandular disorder.			
Anaemia or blood disorder.			
Ears, nose and throat problems.			
Glaucoma, eye problems.			
Sexually transmitted infection, HIV / AIDS.			
Tropical disease, malaria etc.			
Blood transfusion.			
Skin problems, eg eczema, psoriasis.			
Sterilisation or vasectomy.			
Disease of ovary, cervix or uterus.			
Any other condition, surgical operation, tumour or serious injury.			

TESTS and INVESTIGATIONS

Have you had any of the following tests?

	Details	Where?	When?
X-ray, mammography, CT or MRI scans, ultrasound			
ECG, echocardiogram, angiogram			
Endoscopy, colonoscopy			
Other specialist investigation			

FAMILY HISTORY

	Age(s) if alive	Age at death	State of health / cause of death
Father			
Mother			
Brothers			
Sisters			
Sons			
Daughters			

Do you have any family history of:

	Yes	Details		Yes	Details
Diabetes			Aortic aneurysm		
Heart attack			High blood pressure		
Angina or bypass			Glaucoma		
Bowel cancer			Prostate cancer		
Breast cancer			Osteoporosis		
Ovarian cancer			Stroke		

HOSPITAL ADMISSIONS

Please give details of any hospital admissions in the last three years:

MEDICATION

Please list any medicines or supplements you are taking, either prescribed or bought over the counter :

ALLERGIES

Please list any allergies, *including allergies to medicines :*