Dr Dermot O’Flynn

MB Bch BAO

2 Lower Sloane St, London SW1W 8BJ

**New Patient Registration Form – Adult**

The information provided will be held in the STRICTEST CONFIDENCE by The Practice and is protected under the Data Protection Act, and within the security of your medical file.

**Your Details** (Please complete in BLOCK CAPITALS)

|  |  |  |  |
| --- | --- | --- | --- |
| **Title:** (please circle) | Ms / Miss / Mrs / Mr / Dr / Other | **Title if other:** |  |
| **Forename(s):** |  | **Date of birth:** | \_ \_ / \_ \_ / \_ \_ \_ \_ |
| **Surname:** |  | **Gender:**  |  |
| **Telephone number:** |  | **Mobile:** |  |
| **E-mail:** |  |
| **Home address:** |  |
| **Address whilst in UK:***(if non-UK resident)* |  |
|  Please tick this box if you DO NOT want medical results communicated via e-mail. |

**Medical Information and Support**

|  |  |
| --- | --- |
| **Allergies:** |  |
| **Current medication:** |  |
| **Past Medical History** |  |
| **Family Medical History** |  |
| **Name and address of your regular GP / Doctor:** |  |
| **Foreign Travel** |  |
| **Immunisation status** |  |
| **Smoker / Ex-Smoker / Non-Smoker** |  |
| **Alcohol Units per week** |  |
| **Any mobility issues or special assistance needed?** | YES / NO (please circle) |
| **How can we help make your visit more convenient?** |  |
|   Please tick this box if you DO NOT give The Practice consent to share medical information with your GP/doctor. |
|  |

**Next of Kin / Emergency Contact Details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Address:** |  |
| **Telephone number:** |  |
| **Relationship:** |  |

**Declaration**

* The above information is true to the best of my knowledge and I understand that I am financially responsible for my account.
* I consent to Dr O’Flynn or his locum carrying out an examination as required. I also consent, following discussion with him during the examination/consultation, to treatment(s) he recommends if I decide to pursue these.
* I authorise release of my clinical notes to other doctors or other parties only when I have specifically requested it either in writing or by email to Dr O’Flynn
* I am happy to provide photo id for registration purposes.
* I understand that my medical records will be stored on a computerised medical database. There is no link to any NHS Medical Records or other medical database.
* In signing this agreement I am confirming my responsibility for the settlement of my fees as outlined in the FAQ section at [www.drdoflynn.com](http://www.drdoflynn.com) . I have read the FAQ and agree to the terms of practice as outlined.
* I do / do not request a chaperone during examinations (please circle).
* I do / do not want my communications from the practice encrypted (please circle).

Patient Signature: .................................................................................. Date: .................................................

**FOR OFFICE USE ONLY**

|  |  |  |  |
| --- | --- | --- | --- |
| **ID verification carried out by:** |  | **Date of registration:** | \_ \_ / \_ \_ / \_ \_ \_ \_ |
| **Proof of identity provided:** | Driving Licence / Passport / National I.D. Card / Other (please circle) |
| **If other, please specify:** |  | **Address verified:** | YES / NO (please circle) |