

REGISTRATION FORM

1

Name

Date of birth *Mr Mrs Miss Ms**

Address

.....

.....

.....

Tel. Home

Tel. Work

Mobile

Email

2

NHS GP Name

Address

.....

.....

Tel

*I **WOULD / WOULD NOT*** LIKE YOU TO WRITE TO MY NHS GP AFTER EACH CONSULTATION.*

3

Due to the size of the Practice, we are unable to provide a chaperone during examinations. If you require one, it will be necessary for you to bring one yourself.

*I AM **WILLING / UNWILLING*** TO BE EXAMINED WITHOUT A CHAPERONE.*

4

.....
Patient's / Parent's signature

.....
Date

DR GUY STAIGHT &
DR CAROLINE BEALING
2 PELHAM STREET
LONDON SW7 2NG
TELEPHONE 020 – 7581 4222

** Please delete as appropriate*

FAX 020 – 7581 4676