



MOORE MEDICAL PRACTICE

272 Kings Road
London SW3 5AW
www.drsimonmoore.co.uk

Tel: 020 7349 1490
Fax: 020 7349 1491
info@drsimonmoore.co.uk

Dr Simon Moore, Dr Kristina Brovig, Dr Amy Morris,
Dr Iona Cobb, Dr Sarah Al-Temimi, Dr Anna Moore

REGISTRATION FORM

PATIENT'S NAME:- .....

ADDRESS:- Main Address Alternative Address
.....
.....
.....

DATE OF BIRTH ..... MOBILE NUMBER:- .....

TEL - HOME:- ..... TEL: OFFICE:- .....

FAX - HOME:- ..... FAX:OFFICE:- .....

PRIVATE EMAIL ADDRESS .....

If you are happy for the practice to email you results of tests, medical reports, letters from consultants, invoices etc
PLEASE TICK THE APPROPRIATE BOX [ ] YES [ ] NO

MARRIED / SINGLE (please circle)

NHS GP:- NAME ..... TEL .....
ADDRESS .....

I WOULD / WOULD NOT LIKE YOU TO WRITE TO MY NHS GP AFTER EACH CONSULTATION
Please delete as appropriate

I AM HAPPY / UNHAPPY TO BE EXAMINED WITHOUT A CHAPERONE. Please delete as appropriate
DUE TO THE PRACTICE HAVING A SMALL NUMBER OF STAFF, WE ARE UNABLE TO PROVIDE CHAPERONES
DURING EXAMINATIONS. IF YOU DO REQUIRE ONE, PLEASE BRING YOUR OWN CHAPERONE.

CHILDREN'S NAMES: (please complete a separate form for each child if they are registering with this practice)

Table with 3 columns and 2 rows for children's names.

FEES POLICY: Please note that fees should be paid directly to the Practice and not through an insurance company. If you need a receipt for insurance, please ask for this at the time you settle your bill.

We accept credit cards, except American Express or Diners. Fees are usually payable at the time of the consultation but if this is not possible, telephone payments by credit card are also accepted. Cheques should be made payable to MOORE MEDICAL PRACTICE LIMITED.

A cancellation charge of 50% of the fee will be levied if less than 4 hour's notice is given

Please note that fees must be settled within 30 days from the date of the consultation.

Kindly add your medical information to page 2



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## PATIENT MEDICAL INFORMATION

**Name:** ..... **Date of Birth:** .....

**Reason for first consultation:** .....

**Medical History:**

**Current Medications:**

**Allergies:**

Vaccinations: Name	Dates Given

**SIGNATURE:** ..... (parent to sign for children under 16). **DATE:**.....

Copies of the Practice Information leaflet are available at the practice and on the website.