The Harley Street General Practice

PATIENT CONTRACT

This contract confirms that The Harley Street General Practice will provide medical consultations, examination, diagnostic and management medical service to patients who are registered.

The hours of provision for these services and facilities generally operate between 8.30am to 5.30pm Monday to Friday.

Out-of-hours cover is **NOT** supplied by The Harley Street General Practice.

We recommend that patients maintain registration with their NHS practitioners so that they can also receive care within the National Health Service.

The Harley Street General Practice respects the full needs of their registered patients. They endeavour to work within the limits of their abilities and to refer to specialist practitioners where deemed appropriate. Facilities will be regularly reviewed and updated with equipment being calibrated and serviced on a bi-annual basis.

In return for the receipt of services and facilities, these will be charged as noted in the terms and conditions. These must be settled immediately before leaving the premises.

I agree to the terms and conditions of The Harley Street General Practice.

Name: .....

Signed:.....

Date:.....

This practice complies with the Data Protection Act. Information concerning your health will be kept confidential. However, please be aware that information you give us may be recorded and may be shared in order to provide you with care. It may also be used to support local clinical audit and other work to monitor the quality of care provided, on an anonymous basis. If you have any questions about this, please do not hesitate to contact us.

The Harley Street General Practice

PATIENT CONTACT DETAILS

To help us comply with the National Health Care Commission Standards,
please complete this form as fully as possible.

Title:		Sex:	Male / Female
Surname:		Marital Status:	
Forenames:		Nationality:	
DOB:	Age.....	Occupation:	
Address: (For all Correspondence) Postcode:		Address 2: Postcode:	
Home Tel:		Home Fax:	
Work Tel:		Work Fax:	
Mobile No:		Other:	
Email:			
Are you willing to allow us to communicate with you by email? YES / NO Please sign.....			
Do you have an NHS GP?	Yes / No	Next of Kin:	
NHS GP:		Relationship:	
Address: Postcode:		Address: Postcode	
Tel No:		Tel No:	
Do you have Private Health Insurance?	Yes / No		

The Harley Street General Practice

PERSONAL MEDICAL HISTORY AND CONSENT

Name:..... DOB:.....

Please list important past illnesses, operations and accidents:
asthma, blood pressure, high cholesterol, heart disease, migraine, arthritis, diabetes, thyroid problems, cancer, depressive illness: (If possible please state approximate year, place, hospital & specialist):

Medications (including oral contraceptives, inhalers, vitamins, & supplements):

Allergies (drug / non-drug / food):

Do you smoke? Yes / No If yes, how many per day? _____

Have you had a tetanus vaccination in the last 10 years? Yes / No year? _____

Approximate date of last cervical smear (women) _____/_____/_____

Result of smear: Normal / Abnormal / Unsure / Other: _____

Date of any previous Health Assessments _____/_____/_____

Do you have any other comments?

I consent to communication with my NHS GP where appropriate YES / NO

I would like a chaperone to be present during physical examinations NO / YES

I have read a copy of The Harley Street General Practice – Patient Guide YES / NO

I have signed the patient contract YES / NO

Signed: _____ Date: _____