

Prof Klaus Martin Schulte

The Review Clinic

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**New Patient Registration Form**

Patient name: .....

Date of Birth: ..... Referred by .....

Address: .....

.....

Tel. No. ....

E mail .....

Allergies .....

- I consent to Prof KMS and his associates at The Review Clinic 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 Prof KMS
- I consent to receiving results and correspondence from Prof KMS via email.
- Insurance Auth Code .....
- Insurance Membership Number .....
- In signing this agreement I am confirming my responsibility for the settlement of my fees as outlined in the FAQ section on the website [www.thereviewclinic.com](http://www.thereviewclinic.com). I have read the FAQ and agree to the terms of practice as outlined.

Patient /Guardian/Carer Signature ..... Date: .....

