

REGISTRATION No.	Input by (Initials)
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Date of Registration.....

FEMALE:

Ms/Miss/Mrs.

MALE:

Current Surname:	Current Surname:
Current Forename:	Current Forename:
Surname at birth:	Surname at birth:
Forenames at birth:	Forenames at birth:
Date of Birth:Age:	Date of Birth:Age:.....
Town of Birth:Reg.District.....	Town of Birth:Reg.District.....
Country of Birth:	Country of Birth:
Occupation:	Occupation:

UK Address.....	
Date of Entry to UK: (if applicable) E-Mail Address:	
Passport No: Female	Passport No: Male
NHS No: Female	NHS No: Male
Home Address: (if different from above)	
E-Mail Address:	
Home No:	Mobile No:..... Work No:.....
Religion: Female.....	Male
Nationality: Female.....	Male
Translator Name:	Translator Tel No:

General Practitioner (female)	Consultant (female)
Name:	Name:
Address:	Address:
General Practitioner (male)	Consultant (male)
Name:	Name:
Address:	Address:



Formerly known as: The Assisted Conception Unit

The Centre for Reproductive & Genetic Health

University College Hospital The New Wing Eastman Dental Hospital 256 Gray's Inn Road London WC1X 8LD

t. 020 7837 2905 f. 020 7278 5152 www.crgh.co.uk info@crgh.co.uk

The Assisted Conception Unit Ltd., registered in England no. 2441897, 13 Albemarle Street, Mayfair, London W1S 4HQ

On call mobile: 07801 079 524

CRGH TERMS OF PAYMENT

It is the policy of CRGH that all patients must leave details of either a credit or debit card before their first appointment. Patients will be required to pay in full for their treatments prior to commencing with CRGH. You may decide to obtain blood tests/medication outside CRGH. It is your responsibility to ensure that the test results are received by the unit in order not to delay your treatment. Price Lists are clearly displayed in our reception/waiting area and are available upon request. There will be instances where additional costs will be incurred, for additional blood tests, or medication, for example. CRGH's accounts team will contact you to advise you that they will be debiting the charges from your credit card.

The prices given are for the most common procedures performed. All other prices are displayed in the waiting room and are available upon request. Treatment prices do not include any investigations, bloods, drugs required for ovarian stimulation or the Human Fertilisation and Embryology Authority licence.

Please complete the 'Card Details' form attached.

I/We hereby confirm that I/we have read the Paying Your Bill information leaflet and read the Charge Form.
I/We therefore agree to abide by the policy of CRGH and the Terms and Conditions of Payment.

For Funded Patients Only

I acknowledge that the PCT will fund up to the limit set out in the guarantee letter.

Signature.....	Signature.....
Print Name.....	Print Name.....
Date.....	Date.....

S:/ISO Accreditation/CRGH Manual/ Registration Form	Author: CRGH
Document No: PD001	Last Reviewed by: PS/Date Dec-09
Version No: 2	Ratified by: PS/Date Dec-09
Page 2 of 3	Next Review:/Date Dec-10
	Initialed by:.....

