

**Please enter details below in  
block capitals**

Full Name

\_\_\_\_\_

Date of Birth:        /        /

If your address or place of residence has  
changed since originally registering with  
the practice could you please enter your  
latest address here:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PLEASE ENSURE YOU PROVIDE  
PROOF OF ID WHEN MAKING ANY  
CHANGES.**

Home Contact Number: .....

Email Address:.....

Would you be happy to receive notifications  
from the practice via text?

**YES / NO**

If **YES** please provide your mobile phone  
number in the space below.

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Do you have a disability or sensory loss which  
makes communication with the practice difficult  
for you?

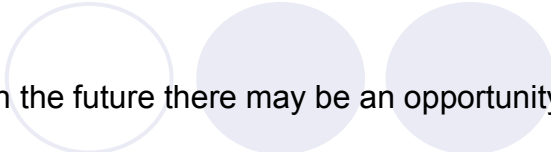
**YES / NO**

If **YES** please describe the difficulties you  
encounter and how the practice can help  
to assist and meet your communication  
needs.



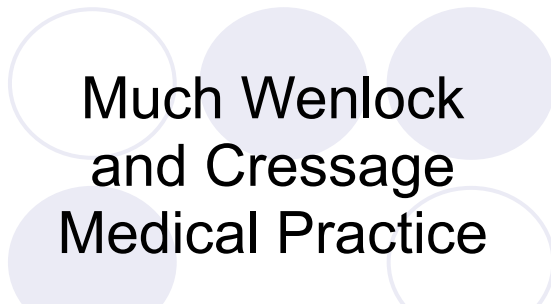
Please use the space below to  
record any difficulties you face  
and any solutions that assist you.

Large empty rectangular box for recording difficulties and solutions.



In the future there may be an opportunity for video consultations for doctor to patient contact. If this facility becomes available would this additional service be of interest to you?

**YES / NO**



## Much Wenlock and Cressage Medical Practice

**To help us  
communicate effectively  
we are updating our  
patient contact details  
and would be grateful  
if you could complete  
and hand this form  
into reception.  
Thank you.**