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.

_ _

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.

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.