

**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.

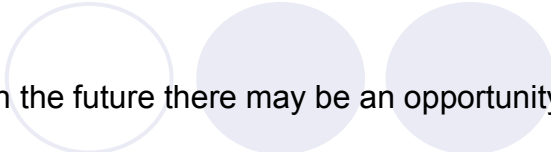
Do you have a disability or sensory loss which
makes communication with the practice difficult
for you?

YES / NO

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

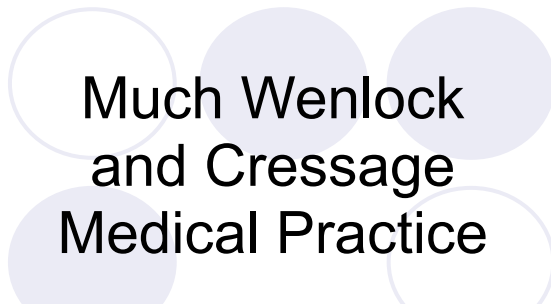


Please use the space below to
record any difficulties you face
and any solutions that assist you.



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.

