Date:

PATIENT GROUP SIGN-UP FORM

All information received will be strictly confidential. All fields marked with a * are mandatory. Please fill in all fields in BLOCK CAPITALS.

Name* *(Last, First):*
Email address*:
Telephone*:
Postcode*:

The information you provide below will be used to ensure our patient group is representative of all our patients.

Age group	☐ Under 16 ☐ 17-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65-74 ☐ 75-84 ☐ Over 84	
Which ethnic group do you most closely identify with?	*White*	☐ British group ☐ Irish
	Mixed	☐ White / Black Caribbean ☐ White / Black Asian ☐ White / Black African
	Asian / Asian British	☐ Indian ☐ Bangladeshi ☐ Pakistani
	Black / Black British	☐ Caribbean ☐ African
	Chinese / Other	☐ Chinese ☐ Any other
How often do you visit the surgery?	☐ Regularly ☐ Occasionally ☐ Rarely	

Thank you for choosing to be part of our Patient Representation Group.

The information you supply us will be used lawfully, in accordance with the Data Protection Act 1998. The Data Protection Act 1998 gives you the right to know what information is held about you, and sets out rules to make sure that this information is handled properly.