SHAWBIRCH MEDICAL CENTRE

PATIENTS PARTICIPATION GROUP

NEW MEMBERS REGISTRATION FORM

Name: _____

Address: _____

_____

_____

Tel., Home: _____

Mobile: _____

E-Mail Address: _____

Do you agree to your e-mail address being shared amongst the Group Members? Yes No

Have you signed the Group's Confidentiality Agreement Yes No

The information below will help us to receive feedback from a representative sample of the patients registered at Shawbirch Medical Centre.

a. Your Gender: Male ☐ Female ☐

b. Your Age: Under 16 ☐ 25 - 34 ☐ 45 - 54 ☐ 65 - 74 ☐

17 - 24 ☐ 35 - 44 ☐ 55 - 64 ☐ 75 - 84 ☐ Over 84 ☐

c. The ethnic background with which you most closely identify is:

White, British Group ☐ Irish ☐

Mixed, White & Black Caribbean ☐ White & Asian ☐ White & Black African ☐

Asian or Asian British, Indian ☐ Bangladeshi ☐ Pakistani ☐

Black or Black British, Caribbean ☐ African ☐

Chinese or Other Chinese ☐

Any Other ☐

d. How often you visit the practice? Regularly ☐ Occasionally ☐ Very rarely ☐

Signature: _____ Date: _____

Secretary's Signature: : _____ Date: _____