LOY MEDICAL CENTRE VIRTUAL PATIENT GROUP SIGN UP FORM

If you are happy for us to contact you periodically by email, please leave your details below and hand this form in at reception.

Name: _____

Email Address: _____

Telephone: _____

Postcode: _____

The information below will help to make sure that we receive feedback from a representative sample of the patients registered at this practice.

Your Gender: ☐ Male ☐ Female

Your Age:

☐ Under 16 ☐ 17 – 24

☐ 25 – 34 ☐ 35 – 44

☐ 45 – 54 ☐ 55 – 64

☐ 65 – 74 ☐ 75 – 84

☐ Over 84 ☐ Over 84

The ethnic background with which you most closely identify is:

White	☐ British Group	☐ Irish
Mixed	☐ White & Black Caribbean	☐ White & Black African
	☐ White & Asian	
Asian or Asian British	☐ Indian	☐ Pakistani
	☐ Bangladeshi	
Black or Black British	☐ Caribbean	☐ African
Chinese or Other	☐ Chinese	☐ Any Other

How would you describe how often you come to the practice?

☐ Regularly ☐ Occasionally ☐ Very rarely

Thank you

Please note that we will not respond to any medical information or questions received through the survey.

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.