PATIENT REGISTRATION FORM

Under the General Data Protection Regulation, I have a 'legitimate interest' in collecting some personal data from you. Please see my full Privacy Policy for more details.

TITLE:	**NAME:**	
ADDRESS:		
	POSTCODE:	
DATE OF BIRTH:	**DOCTOR'S SURGERY:**	
CONTACT DETAILS: I will never share your data with anyone who does not need access without your written consent. These details are stored on paper records and on the office computer/clinical software system. Please only give me details that you are happy for me to use to contact you regarding your appointments and medical care.		
TELEPHONE: **(Home)**	**(Mobile)**	
EMAIL:		
MARKETING PREFERENCES: With your consent, I may occasionally send you general health information in the form of articles, advice or newsletters. I may also send discount special offers. **Please tick ✓ to opt IN.** You may withdraw your consent at any time		
Post	**Email**	**SMS**
CONSENT: I confirm that I have read and understood the patient information sheet and consent to be treated in the manner described.		**Please tick ✓**
PRIVACY: I confirm that I have read and accept the privacy policy.		
FEES: I confirm that I am responsible for the payment of fees.		
CANCELLATION: I understand that if I cancel an appointment with less than 24 hours notice, I may be charged a cancellation fee of up to the full fee.		
SIGNATURE:		**DATE:**
If signing on behalf of a minor, please give your name and relationship to the above patient		
Name:	**Relationship:**	