

BISCOT GROUP PRACTICE

PATIENT REFERENCE GROUP - CONTACT FORM

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

Name: _____.

Email address: _____.

Postcode: _____.

This additional information will help to make sure we try to speak to a representative sample of the patients that are registered at this practice.

Are you: Male Female

Age group:

Under 16 17 - 24 25 - 34 35 - 44

45 - 54 55 - 64 65 - 74 75 - 83

Over 84

To help us ensure our contact list is representative of our local community please indicate which of the following ethnic background you would most closely identify

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 ethnic Group

Chinese Any Other

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

Regularly Occasionally Very Rarely

Thank you.

*Please note that no medical information or questions will be responded to.
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 being held about you, and sets out rules to make sure that this information is handled properly.*