Holt Medical Practice Patient Participation Group Registration Form

To register for the Patient Participation Group, please complete your details below and hand this form back to reception.

Name: ____

Email address: ____

Address including Postcode: ____

Are you a patient of Holt Medical Practice?

Yes □

No □

Are you a carer? Yes □ No □

Are you? Male □ Female □

Age Group	Under 16		17 – 24	
	25 – 34		35 – 44	
	45 -54		55 – 64	
	65 -74		75 - 84	
	Over 84			

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

Are You?							
White		White Irish		Black Caribbean		Black African	
White & Black Caribbean		White & Black African		White and Asian		Other Mixed	
Indian		Pakistani		Bangladeshi		Chinese	
Caribbean		African		Other black		Other Asian	
Other Ethnic Group (please specify)							

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

Regularly ☐

Occasionally ☐

Very rarely ☐

THANK YOU VERY MUCH FOR YOUR PARTICIPATION

Please note that no medical information or questions will be responded to.