

BILLINGSHURST SURGERY

Signing up for our Patient Reference Group

If you are happy for us to contact you periodically by email please complete the details below and hand this form in at Reception.

Name: _____

Email Address: _____

Telephone: _____

Post Code: _____

The information below will help us make sure that we receive feedback from a representative sample of 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

Are you (tick all that apply)?

At school A parent Employed Retired

A carer

Do you have a long term condition? Yes No

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

Regularly Occasionally Very rarely

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