PLEASE COMPLETE THE FORM BELOW AND RETURN IT BY EMAIL OR BRING IT TO YOUR FIRST APPOINTMENT

New Patient Registration Form

Title Given Names

Surname

Preferred pronouns

Address

Date of Birth

Phone number

Email

Mailing address

Privacy Statement

Your privacy is very important to us. As part of normal operations, we may collect certain information from you. We will only collect personal and health information that is necessary for providing the services offered to you. Your information will not be disclosed without your prior consent, other than required by law or for billing purposes. If you require access to your medical file, you need to request it in writing. Referral to other health providers (which might be discussed during your consultation) implies consent to disclose relevant personal and health information to such providers.

By signing below, you are giving consent to Dr Amelia Haines to hold and use your personal and health information for these appropriate purposes, and if required to request your healthcare information and reports from other practices or practitioners to assist with your care.

I have read the above Privacy Statement and agree to the collection of my personal and health information. (If your child is under 16, please sign on their behalf).

I authorise Dr Amelia Haines to release medical information to the referring doctor/ health provider, insurance company, solicitor or other persons nominated by me or as discussed with me in consultation.

Signed	Date: (dd/mm/yyyy)