# Riverport Medical Practice

## Patient Group Registration Form

Name:_____

Date of Birth:_____

Address:_____

_____Post Code:_____

Telephone Number:_____

Email Address_____

Usual Site *(please tick)*

Orchard Site ☐

Parkhall Site ☐

Fenstanton Site ☐

Consent

Riverport Medical Practice and The Patient Group will need to contact you from time to time regarding Patient Group activity, upcoming events and meeting dates. Please advise us below on how you would like to be contacted. Please provide us with at least two forms of communication.

Telephone ☐ Post ☐

SMS text messaging ☐ Email ☐

Print Name_____

Signed_____ Date_____