# KENNEDY WAY SURGERY

**Kennedy Way, Yate, S.Glos, BS37 4AA**
**Telephone: (01454) 313849 (day and night)**
**Email: bnssg.kws@nhs.net**

**Welcome to our Practice**

Please complete the form below which provides us with some additional information that will assist us in providing you with the best care- please complete the following questions for each patient aged over 16 who is registering with us- Thank You

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|---|---|---|---|
| **Family Name:** | | | |
| **Forename:** | | | |
| **Middle Name:** | | | |
| **Prefer to be known as:** | | | |
| **Does anyone hold a Power of Attorney document for you:** | | Yes | No |
| If yes please provide their name and contact number: | | | |
| Name: | | | |
| Contact Number: | | | |
| Can you provide the surgery with a copy of this document: | | Yes | No |

**Telephone calls to and from the Surgery may be recorded for training and monitoring purposes**

The practice offers patients the opportunity to receive SMS messages to confirm appointments and to receive information from the surgery such as test results.

This is an additional service and patients should be aware that they may not be sent on all occasions.

Text messages are generated using a secure facility that are then transmitted over over a public network on to a personal telephone and as such may not be secure.

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| **If you do not wish** to receive text messages from the surgery please tick the box: | |

**If you do wish** to receive texts from the surgery please complete the information on the following page:

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|---|---|---|
| I confirm that the mobile telephone number listed on the | | |

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|---|---|---|
| registration form is my own personal number and is not shared with anyone else: | Yes | No |
| I consent to the Practice contacting me by text message for the purpose of appointment reminders and information from the Practice regading my healthcare, health promotions and updates | Yes | No |
| The practice may contact you via email with general information. We will not use email to provide any confidential information and we cannot answer or respond to any emails requesting appointments with the clinicians. | | |
| I consent to the Practice contacting me by email for the purpose of sharing general information and health promotions: | Yes | No |
| I confirm that the email address listed on the registration form is my own personal email address and is not shared with anyone else: | Yes | No |
| Please state any serious illness- in particular heart disease, cancers, strokes, high blood pressure, diabetes or inherited diseases that are present in your immediate family: | | |
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| **Please sign and date this form when completed:** | | |
| **Signature:** | **Date:** | |