**Patient Registration Form** (Talking Therapy Clients)

\*Required Information

**1.** **Full Name\*** ………………………………………………………………………………………………

**2.** **Date of Birth\*** ……………/………………………/………………….

**3.** **Address\*** …………………………………………………………………………………………………….

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………………………………………………………………… **Postcode\*** ………………………………….

**4.** **Email Address** …………………………………………………………………………………………..

**5.** **Home Phone Number\*** ……………………………………………………………………………….

or

**6.** **Mobile Number\*** ………………………………………………………………………………………..

**7.** **Employer** ……………………………………………………………………………………………………

**8.** **Occupation** ………………………………………………………………………………………………..

**9.** **GP Name\*** …………………………………………………………………………………………………

**10.** **GP Practice\*** ……………………………………………………………………………………………

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**11**. **Please state which service are you coming to us for? ……………………………………………………..**

**13.\*** **I have read and understood the provided information booklet and understand what the treatment is likely to involve, the benefits and potential risks.**

**Signature** ……………………………………………………

**Date** ………………………………………………………….

All of your personal records are confidential and we will never share your details with anyone else. We will use the details you provide to contact you via email/telephone/text/post in relation to any appointments that you have with us and to share any important information with you. We may from time to time contact you via email with special offers and important information that we may think is useful to you. If you do not wish to be contacted I this was please indicate below.

Yes I wish to be contacted No I do not wish to be contacted