

# WELCOME TO THE CLINIC

Please fill in this form in BLOCK CAPITALS so we can register you to be seen in the clinic today

IF YOU HAVE ANY DIFFICULTY COMPLETING THIS FORM PLEASE SPEAK TO RECEPTION STAFF

All information that you submit is  
**STRICTLY PRIVATE & CONFIDENTIAL**

<b>Surname:</b>		<b>Forename:</b>	
<b>Date of birth:</b>	<b>Age:</b>	<i>Please circle gender</i> <b>Male / Female</b>	

IT MAY BE NECESSARY FOR US TO CONTACT YOU

Please provide as many contact details as possible (*Please circle the appropriate contact*)

<b>Home address:</b>		<i>YES/NO</i>	
<b>Postcode:</b>			
<b>E-mail address:</b>		<i>YES/NO</i>	
<b>Mobile number:</b>	<i>YES/NO</i>	<b>Home number:</b>	<i>YES/NO</i>

**Relationship status:** *Please circle appropriate:* In relationship / not in relationship

<b>Name &amp; address of your GP:</b>	
<b>How would you describe yourself:</b> <i>Please circle appropriate</i> Asian/Oriental Black African Black Caribbean Black other Indian/Pakistani/Bangladeshi Other/mixed White	
<b>Country of birth:</b>	
<b>How did you hear about the clinic?</b> <i>Please circle appropriate</i> Contact Slip / Doctor or Nurse / GP referral / Contraception services / Other professional Partner / Friend / Radio / Newspaper / Internet / Leaflet / Other.....	
<b>Is this your preferred clinic?</b> YES / NO <i>Please circle appropriate</i>	
<b>Did you try contacting another clinic before coming here?</b> YES / NO <i>Please circle appropriate</i> If so where.....?	
<b>What do you want from the clinic today?</b> <i>Please circle appropriate</i> <ul style="list-style-type: none"> <li>• I'd like to have a check up/tests</li> <li>• I'd like to see a contraceptive Doctor/Nurse</li> <li>• I would like to talk to someone</li> <li>• I'm not sure</li> </ul>	