QUEENS ROAD MEDICAL PRACTICE

Accredited by CHKS Insight for better healthcare

FOR OFFICE USE ONLY
To be completed when clinical system updated

Staff Initials: _____
Date: _____

Change of Name Form (only)

For Changes to address/contact/phone numbers please use: Updating Contact Details form

Current Registered Full Name	
Name Change	
Date of birth	
Gender Identity	

Contact details	
Primary Contact Number	Mobile:
	Telephone:
Email Address	
Please only provide your email address if you are happy to receive communication as follows: *We use email to:* *- Provide communication about your personal medical care* *- Send invoices* **Email address: _____**	
Address	

Please provide a copy of proof of change with this form, an example of this could include a marriage certificate or passport.

It is your responsibility to update the States of Guernsey and all other relevant departments of your name change. If you do not inform them of the change investigations or referrals may be declined.

To be signed by Patient if aged 12 years or over. **To be signed by parent/guardian for patients under the age of 12 years.**			
Signature		**Date**	
Print Name			

Please leave this form at reception or email the relevant details to admin@eqrmp.com

Your details will be stored and used as per our Privacy Notice; This can be viewed on our website and is also available upon request from reception.

Staff note – This form is to be scanned into patient records.