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| --- |
| Please complete all sections in **BLOCK CAPITALS** to enable accurate data capture |
| Title: | First Name:  | Surname: |
| Date of birth: | Sex: (please circle) Male / Female  |
| Landline Tel No:  | Mobile:  |
| Email address:  |
| Your address: County: Postcode: |
| Have you been to our clinics before, if so what year? |
| Nationality:  |
| ETHNICITY:**White** British [ ]  Irish [ ] **Mixed** White and Black Caribbean [ ]  White and Black African [ ]  White and Asian [ ]  **Asian or Asian British** Indian [ ]  Pakistani [ ]  Bangladeshi [ ]  **Black or Black British** Caribbean [ ]  African [ ] **Chinese or Other ethnic group** Chinese [ ]  **Any other background, please write in:** |
| GP Name: Practice Name and address: |
| Reason for visiting clinic? (please circle) | Leisure travel | Business travel | Occupational health | LSTM staff/student | Other |
| Occupation: |
| If travelling for work purposes please insert company details and contact person:Type of business: |
| **Children under 18 only –** name and address of school/college presently attending: |
| A fee is charged for all services provided at this clinic, including an appointment fee. We reserve the right to change our prices at any time. Please refer to the price list or look on our website for an up to date list of all clinic charges. Signing this form is your agreement to agree to pay all chargesData Protection Act NoticeThe information we hold about you may be shared with our finance department and the person/company paying your bill (for invoicing purposes).  Signing this form is your agreement for us to share that data. Please tick if you DO NOT want us to use your data for marketing and audit purposes Please tick if you WOULD like us to send reminders to you about scheduled vaccinationsSignature: ................................................. Date: ................................ |