

# PRINCES GARDENS SURGERY

## CHANGE OF NAME

PREVIOUS NAME	
DATE OF BIRTH	
ADDRESS	
TELEPHONE NUMBER	
MOBILE NUMBER	
E MAIL ADDRESS	

NEW NAME	
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- A separate form should be used for each person.
- Children or adults aged 16 years or over will be required to complete and sign their own form.
- Both Parents / Guardians of children under the age of 16 years must sign on behalf of their children.**

	PATIENT/ PARENT/GUARDIAN	PATIENT/PARENT/GUARDIAN
SIGNED		
PRINT NAME		
RELATIONSHIP TO PATIENT <small>(if not patient)</small>		
DATE		

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### FOR OFFICE USE ONLY

<input type="checkbox"/> PROOF OF NAME CHANGE SEEN	STAFF MEMBER SIGNATURE _____
<input type="checkbox"/> NAME CHANGED IN MEDICAL RECORDS	STAFF MEMBER SIGNATURE _____
DATE _____	