

**CHANGE OF PERSONAL DETAILS**

<b>Please complete all relevant details</b>		
Name		
Date of Birth		
New Address		
Postcode		
Home Telephone		
Mobile Telephone		
We would like to send SMS text messages from the practice. We will not send text messages to mobile phones that are used or shared by more than one person or children who are registered with parents' mobile phone numbers.		
<b>Do you consent for the practice to contact you by SMS text message?</b>	YES	NO
Old Address		
Postcode		
New Name		
<b>Please note that proof must be provided when changing your name. i.e., marriage certificate, deed poll</b>		
Signed		
Dated		

**When completed please hand it in to:**

Sleaford Medical Group, 47 Boston Road, Sleaford, NG34 7HD

OR

Submit via the practice website: [www.sleafordmedicalgroup.co.uk/medical-forms](http://www.sleafordmedicalgroup.co.uk/medical-forms)

**\*PLEASE NOTE\* - a form of ID is required for name and/or address changes.**

Rec Ints		Disp		Date	
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