** Online Services Patient Registration Form**

To register for online services please complete this form and return it to the surgery in person, **along with two valid forms of identification and one must contain a photo, for example your passport, photo driving license, bank statement (NOT utility bills)**. Once you are registered the practice will give you the information that will enable you to create a username and password.

|  |  |
| --- | --- |
| **Patient details** |  **Please complete in BLOCK CAPITALS** |
| Patient forename |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Patient surname |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Date of birth | D | D | / | M | M | / | Y | Y | Y | Y |  |
| Email addressThis email address will be used by your practice to send you notifications and reminders.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Mobile number |  |  |  |  |  |  |  |  |  |  |  |  |
| I wish to have access to the following online services (please tick all that apply): |
| 1. Booking appointments
 |  | 1. Requesting repeat prescriptions
 |  |
| 1. I wish to access my medical record online and understand and agree with each statement below

(*please tick all below to verify*) |  |
| 1. I have read and understood the information provided by the practice
 |  |
| 1. I will be responsible for the security of the information that I see or download
 |  |
| 1. If I choose to share my information with anyone else, this is at my own risk
 |  |
| 1. If I see information in my record that is not about me or is inaccurate, I will contact the practice as soon as possible
 |  |
| Signature |  |
| Date | D | D | / | M | M | / | Y | Y | Y | Y |  |
| Completing the form on behalf of the patient? |
| Print forename |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Print surname |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Relationship to patient |  |
| Signature |  |
| Date | D | D | / | M | M | / | Y | Y | Y | Y |  |
| **Staff use only** | Patient NHS No: |  |
| Type of ID seen | Photo ID and proof of residence |  | Vouched by member of staff |  | Vouching using medical record |  |
| Staff Initials |  |  Date:  |  |
| Level of record access enabled | Prospective  |  | Retrospective  |  |
| All |  | Limited parts |  |
| Contractual minimum |  |  |  |
| Authorised by |  |  Date: |  |
| Notes / Explanation |  |