** 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.

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| **Patient details** | | | | | **Please complete in BLOCK CAPITALS** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient forename | | | | |  | | |  | | | | | | |  | | |  | | | | | | | |  | | | | |  | | | | | | |  | | | | | |  | | | | | | |  | | | | |  | | | | | | |  | | | | | |  | | | | | |  | | | | | |  | | | | |  | | | |  | | | | | | |  | | | |  | | | | | | | |  |
| Patient surname | | | | |  | | |  | | | | | | |  | | |  | | | | | | | |  | | | | |  | | | | | | |  | | | | | |  | | | | | | |  | | | | |  | | | | | | |  | | | | | |  | | | | | |  | | | | | |  | | | | |  | | | |  | | | | | | |  | | | |  | | | | | | | |  |
| Date of birth | | | | | D | | | | | | D | | | | | | | | | | / | | | | | | | | | | | M | | | | | | | | | | M | | | | | | | | | | | | / | | | | | | | | | | Y | | | | | | | | | | | | Y | | | | | | | | Y | | | | | | | | | Y | | | | | | | | | | |  | | | | | |
| Email address  This email address will be used by your practice to send you notifications and reminders. | | | | |  | |  | | | | | | |  | | |  | | | | | | | |  | | | | |  | | | | | | |  | | | | | |  | | | | | | |  | | | | |  | | | | | | |  | | | | | |  | | | | |  | | | | | | |  | | | | |  | | | |  | | | | | | |  | | | |  | | | | | | | |  | |
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| 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 | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |