Application for online access for patients over the age of 16 (booking appointments and requesting repeat prescriptions)

SURNAME	D.O.B
FIRST NAME	
ADDRESS	
EMAIL ADDRESS	
TELEPHONE NUMBER	MOBILE NUMBER
I access to the following online services (please tick all that apply)	
1. Booking appointments	
2. Requesting repeat prescriptions	
3. Receive Text Messages	
I have read and understood the Practice Guidance. I wish to have access to book appointments and request repeat prescriptions. I will contact the practice as soon as possible if I suspect this account has been accessed by someone else without my agreement.	
I am the patient and I am over the age of 16	Yes/No
Patient to sign and date	_____
For office use only	Staff member to complete below
Proof of ID given	Yes(please specify
Identity Confirmed	Yes (please initial)
On line registration documents printed and e-mail verified in patient's record	Print name and sign

Online access to your medical record is available on request. Please ask at reception and they will supply you with a different application form which must be completed in ALL areas indicated.