**Oakleaf Medical Practice online registration form**

To register for this online service please complete this form and return it to the practice along with **both a form of photo ID (for example, your passport) and proof of address (for example, a utility bill).** Once you are registered the practice will give you the information you will need to access the online services.

To get the full benefits of our system upgrade, you can register for electronic repeat prescriptions. **This means the pharmacy will request and be sent your repeat prescription electronically, allowing it to be dispensed more quickly.** To do this, contact your chosen pharmacy who will send the practice an electronic request.

Please complete in **BLOCK CAPITALS**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient forename** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Patient surname** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Patient date of birth** |  |  | **/** |  |  | **/** |  |  |  |  |  |
| **E-mail address** (this will be used to send you notifications and reminders) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Mobile number** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Would you like access to your medical records online?** Yes No

**Would you like access to online booking?** Yes No

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

If completing on behalf of the patient, please provide the following in **BLOCK CAPITALS**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Your forename** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Your surname** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Your relationship to patient** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**STAFF USE ONLY** **#91B** DATA VERIFIED **#93440 NOTES SUMMARY VERIFIED**

Type of patient ID seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staff name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_