

# Old School Surgery

## Patient Registration Form for Online Services

### Appointment booking and cancellation

Have the flexibility to book, check and cancel your appointments from home, at work or any location with internet access. Please remember to cancel any unwanted appointments as soon as possible.

### Request your repeat prescriptions online

Request your repeat prescriptions quickly online by logging into your account and simply ticking the appropriate boxes. You should allow 72 hours for us to process your prescription request before collecting your medication at your nominated pharmacy.

If you would like to register for this online service please complete the form below and return it to your practice in person, **along with a valid form of identification, for example photo ID or your passport.**

Once you are registered the practice will give you the information that will enable you to create a username and password.

### **YOUR FORM WILL NOT BE PROCESSED WITHOUT ACCOMPANYING PHOTO ID**

| Patient details  | Please complete in BLOCK CAPITALS  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Patient forename   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Patient surname  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Date of birth  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Email address<br><small>(Any over 16 years of age must have their own individual email address.)</small>                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Mobile number  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Please complete your details below if you are representing a child or have given explicit consent by a patient to act on their behalf</b> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Print forename   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Print surname  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Relationship to patient (if completing the form for someone else)  | Delete as appropriate<br>Parent <input type="checkbox"/><br>Carer <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature of Parent/Carer  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature of Patient if authorizing a to act on their behalf   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Please read overleaf & sign** (Please note if your form is not signed and verified we will be unable to process your registration for online services).

# Patient Registration Form

## Who can apply?

Patients must be aged 16 years or older to register for an online account. Parents (or those with parental responsibility) may apply for an account on behalf of their children where both parent and child are registered at the Practice, and the child is under 16.

Individuals aged 16 or over must have their own individual email address; this is to ensure your information remains confidentiality. Confirmation emails regarding appointments and repeat prescriptions will be sent to the authorised email account.

Carers may apply on behalf of patients they care for if the carer has legal power of attorney or has been given explicit written consent from the patient.

The practice will email you with your activation letter within the next few weeks. (Please ensure you check your email inbox & junk mail). If you have not heard from the practice within this time frame please contact us.

## By signing I confirm that:

1. I have read and understood the information provided to me by the practice.
2. I will be responsible for the security of my username and passwords and the information that I see or download.
3. If I choose to share my information with anyone else this is at my own risk.
4. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement.
5. I agree to use the system in a responsible manner in accordance with all instructions given to me by the Practice. If not, access may be withdrawn.
6. I agree that my details may be used to contact me with information about my online account and the online services I use.
7. I agree that I cannot use this service as a means of communication with the surgery for other purposes and will not use it for urgent matters.
8. I understand that on-line appointments are only available with the doctors at present.
9. I understand that if I fail to attend and appointment without notifying the practice my account will be deactivated by the practice.

**IF YOU HAVE ALREADY REGISTERED FOR ONLY APPOINTMENTS ONLY PLEASE TICK THIS BOX TO ENABLE US TO UPDATE YOUR EXISTING ACCOUNT**

|  |             |
|--|-------------|
| <b>Please date &amp; sign to confirm that you have read &amp; understand the information above</b> | <b>Date</b> |
|--|-------------|

Practice use only:

|                                       |  |                        |       |
|---------------------------------------|--|------------------------|-------|
| Identity verified<br>Type of ID shown |  | Signature of verifier: | Date: |
| Date account created                  |  |                        |       |
| Date letter sent/mailed               |  |                        |       |