The KEY MEDICAL PRACTICE

Registration form to access online

APPOINTMENTS and PRESCRIPTIONS

Surname			
First name			
Date of birth			
Address Postcode			
Email address			
Telephone number		Mobile number	

I wish to have online access to BOOK APPOINTMENTS and order REPEAT PRESCRIPTIONS.

I will provide the practice with VALID PHOTO ID.

I understand and **agree with each statement** (please tick)

If I choose to share my information with anyone else, this is at my own risk.	☐
I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement.	☐

Please tick ONE of the boxes below:			
I am happy for my login details to be sent to the address above.	☐	Please call me and I will collect my login details from the surgery.	☐

Signature		Date	

For practice use only:

Identity verified through (tick all that apply)	Photo ID ☐ Vouching ☐ Vouching with information in record ☐	Name of verifier	Date
Patient allowed to register for patient services and PIN document issued			