

Patient Facing Services Application Form

Patient to complete:

Name:	
D.O.B:	
Address:	
Telephone No:	
Mobile No:	
E-mail address:	
Practice Guidance read and understood	YES / NO <i>(Delete as appropriate)</i>
	Please indicate whether you would like access to on line prescription requests, on line appointments or access to medical records or all three options. Please tick as appropriate. Prescriptions <input type="checkbox"/> Appointment booking <input type="checkbox"/> Medical Records <input type="checkbox"/>

I am the patient Signed.....

I am representing the patient (If 11 years old or under) Signed..... (Parent/guardian)

Parents/guardians may represent 11 to 15 year olds with their authority
 (the child **must** give permission by signing below)

Please note at 16 years of age the child must apply for Patient Facing Services in their own right

I consent to my parent/guardian applying for EMIS Patient Facing Services on my behalf and collecting my registration documents Signed.....
 Date:.....

PLEASE REMEMBER THAT ID WILL BE REQUIRED FOR THE COLLECTION OF REGISTRATION DOCUMENTS AND PIN NUMBER

(PATIENTS AGED 16 YEARS OLD OR OVER MUST COLLECT THEIR OWN DOCUMENTS)

DISCLAIMER

1 have understood and will adhere to the Practice Guidance for the use of Patient Facing Services. I understand that failure on my part to adhere to the guidance may result in my patient facing services registration being terminated. I understand that this will in no way affect my registration as a patient at the practice.

Signed

Date.....

