CARMEL MEDICAL PRACTICE

Patient Registration Form for SystmOnline Services

*For patients 13 and over*

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| ***Patient Details (please print clearly)*** |
| **Surname** |  |
| **First Name** |  |
| **Date of Birth** |  |
| **NHS number** **(if known)** |  |
| **Full Address including** **Post Code** |  |
| **Email Address** |  |
| **Mobile Number** |  |

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| **I would like to register for online appointments and repeat prescriptions** | *Please circle your answer*Yes No  |
| **I would like to receive appointment reminders by text** | Yes No |
| **I would like to access my Summary Care Record online** | Yes No |

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| **I confirm that I give my permission for the Practice to register me for online services and to communicate via the agreed methods above.** |
| **Signature** |  |
| **Date** |  |