# Beechwood Medical Practice Patient Online Registration Form Access to GP online services

|  |  |
| --- | --- |
| Surname |  |
| First name |  |
| Date of birth |  |
| Address and postcode |  |
| Email address |  |
| Mobile number |  | Landline number |  |

**I wish to access online services and understand and agree with each statement (please tick)**

|  |  |
| --- | --- |
| 1. I have read and understood the information leaflet provided by the practice
 | 🞏 |
| 1. I will be responsible for the security of the information that I see or download
 | 🞏 |
| 1. If I choose to share my information with anyone else, this is at my own risk
 | 🞏 |
| 1. I will contact the practice as soon as possible if I suspect that my account has been accessed by someone without my agreement
 | 🞏 |
| 1. If I see information in my record that is not about me, or is inaccurate I will log out immediately and contact the practice as soon as possible

  | 🞏 |
| Signature |  | Date |  |

### For practice use only

|  |  |  |  |
| --- | --- | --- | --- |
| Identity verified through | **Either** Photo ID 🞏 DL / Passport -  (circle which one seen) **OR** Other Photo ID 🞏 ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**&** Proof of Address 🞏 ­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Name of verifier | Date |
| Emis No: |
|  | Pin details Emailed to patient 🞏 | Date |
| Now pass sheet to Deb Harris (for coding/checking & scanning) |