

LAKESIDE MEDICAL PRACTICE

APPLICATION FORM FOR ON-LINE APPOINTMENT BOOKING AND REPEAT MEDICATION REQUESTS

To access this service, you will need to complete this application form and take it to reception, along with some form of identification such as a bank statement or utility bill. You will then be issued with a letter containing all the information you need to register with the service.

Patient to complete:

Name:	
D.O.B.:	
Address:	
Tel No:	
Mobile No:	
E-mail address:	

I am the patient

I am the parent or guardian of the above named child who is aged under 14

I am the parent or guardian of the above named child who is aged between 14 and 16 who has also signed this form to indicate their consent to me representing them

(If you are the parent of a child aged between 14 and 16 they should sign below and you should bring proof of their signature such as a passport. Alternatively they may come to the Practice and sign the form in front of a member of staff)

If you are bringing this form to the surgery on behalf of somebody else, their registration details will be posted direct to them.

You must also bring with you proof of their signature

Patient's signature _____

Date _____

IF YOU ARE A CHILD AGED BETWEEN 14 AND 16 YOU SHOULD ONLY SIGN THIS FORM IF YOU AGREE TO ACCESS BEING GRANTED TO YOUR PARENT OR GUARDIAN. THIS MEANS THEY WILL BE ABLE TO VIEW YOUR MEDICATION AND IN FUTURE, POSSIBLY YOUR MEDICAL RECORDS

Signature of child _____