Name ­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Post Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address (this must be the email address you will use to register for patient services)

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I agree that I want to sign up for patient services and that my email address provided can be used to set up my account with Linenhall Medical Practice.

Please delete as appropriate

I do not / wish to receive my login details via email

I do not / wish to receive a paper copy of my login details

I do not / wish to correspondence from the practice using my mobile

Date

I accept that by sending this form via email to that I am agreeing to the above.

Please forward a copy to

Prescriptions.Z00227@gp.hscni.net [N.B- capital ‘Z’ and zero zero 227]

**ID CHECK –A COPY OF PHOTOGRAHPHIC IDENTIFICATION MUST BE PROVIDED WITH THIS FORM**

**PLEASE CONTACT THE SURGERY IF YOU DO NOT HAVE THIS AND WE CAN VERIFY YOU ANOTHER WAY**

|  |  |  |
| --- | --- | --- |
| ID CHECKED  | SOURCE OF ID | ADMIN USE ONLY  |
|  |  |  |