TAYVIEW MEDICAL PRACTICE

APPLICATION TO REGISTER FOR ONLINE SERVICES

Our online services allow you to book appointments online, cancel appointments and order repeat prescription medication. You can register for this system by providing your details below.

**Please note, only the patient registering should complete and sign this form.**

All patients aged 16 and over can register to use this service. Unfortunately, for confidentiality reasons, the practice will not accept registrations for any patient less than 16 years of age.

Once the practice has actioned your request, your logon details will automatically be sent to the email address specified below. For this reason, **we strongly advise** that you use an email address that only you have access to in order to maintain your confidentiality. If you are using an email address that other members of your household can access, they will be able to view your logon details and will also receive emails regarding any appointment reminders.

Once you have completed the details below, you can either hand the form into any of our practices or email your completed form to Fife.F21609Tayview@nhs.scot with “ONLINE REGISTRATION” written in the subject box. We will acknowledge receipt of your application via email once it has been received.

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| --- | --- |
| **FULL NAME** |  |
| **ADDRESS** |  |
| **DATE OF BIRTH** |  |
| **TELEPHONE NUMBER** |  |
| **MOBILE NUMBER** |  |
| **EMAIL ADDRESS** |  |

***Please complete the below:***

I CONFIRM THAT I AM THE PATIENT AND HAVE COMPLETED THE INFORMATION ABOVE **YES / NO**

I CONFIRM THAT I HAVE READ THE ABOVE INFORMATION  **YES / NO**

I CONFIRM THAT THE EMAIL ADDRESS PROVIDED ABOVE IS ACCESSIBLE BY MYSELF ONLY **YES / NO**

I CONFIRM THAT THE EMAIL ADDRESS PROVIDED IS ACCESSIBLE TO OTHER MEMBERS OF MY FAMILY AND ACCEPT THAT MEMBERS OF MY FAMILY WILL BE ABLE TO VIEW MY LOGON DETAILS AND ANY APPOINTMENT REMINDERS

**YES / NO**

I NOTE IT IS MY RESPONSIBILITY TO NOTIFY THE PRACTICE OF ANY CHANGES TO MY EMAIL ADDRESS **YES / NO**

|  |  |
| --- | --- |
| PATIENT SIGNATURE | DATE |